Prompt Pay for a Healthy Missouri Project

Report on timeliness of insurer payment to Missouri healthcare providers

Dec. 31, 2009

DIFP
Department of Insurance, Financial Institutions & Professional Registration

John M. Huff, Director

Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

OFFICE OF THE DIRECTOR

December 31, 2009

Office of Governor Jeremiah W. (Jay) Nixon
Post Office Box 720
Jefferson City, Missouri 65102

Re: Prompt Pay Report

The Honorable Jeremiah W. (Jay) Nixon:

In accordance with Executive Order 09-24, I am pleased to submit the following "prompt pay" report detailing the challenges experienced by Missouri health care providers in receiving timely payment from health insurance companies.

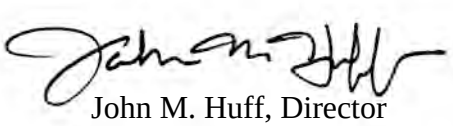
The report recommends Missouri law be strengthened to make the medical claims process more efficient, by providing clear direction to both insurers and health care providers on their roles and responsibilities. While many insurers are meeting their financial obligations to providers, others are not.

Rather than advocate specific statutory language, the report articulates the legislative principles essential to ensure effective and efficient medical claims processing in Missouri. Also, where appropriate, I will order a number of regulatory actions by the department, including market conduct examinations of health insurance companies.

This report is based on data provided by Missouri hospitals, which were surveyed with the assistance of the Missouri Hospital Association. The survey was designed to determine the extent of payment delays and to identify areas that could benefit from stronger state laws and additional regulatory action.

It has been a privilege to investigate an issue that impacts virtually all Missourians and to provide what the department believes are constructive solutions.

Sincerely,



John M. Huff, Director
Missouri Department of Insurance,
Financial Institutions and
Professional Registration

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Executive Summary

In 2008, Missouri insurers paid out $10.4 billion to satisfy health insurance claims, an amount equal to nearly 5 percent of Missouri's GDP.[1] Of this amount, the carriers included in this report paid $5.1 billion. In spite of the large sums paid during any given year, providers continue to express dissatisfaction with the claims handling processes by insurance carriers.

In September of 2009 Governor Jay Nixon issued Executive Order 09-24 establishing the Prompt Pay for a Healthy Missouri Project ("the Project") to inquire into the timeliness of payment to Missouri medical providers by health insurers. The director of the Missouri Department of Insurance, Financial Institutions & Professional Registration (DIFP), John M. Huff, was designated Project Director and directed to issue a report on the scope of the problem by December 31, 2009. This report satisfies that requirement.

Based on the findings, it is apparent the Missouri prompt pay statute, effective in 2002, has had only a modest impact on claims processing times, and that substantial amounts owed to medical providers remain unpaid for extended periods of time. While slow processing times impact virtually all hospitals throughout Missouri, smaller rural providers are more sensitive to interruptions to cash flow, and appear to experience significantly elevated claim payment times. The report concludes by identifying possible ways that the Missouri prompt pay statute might be made more effective.

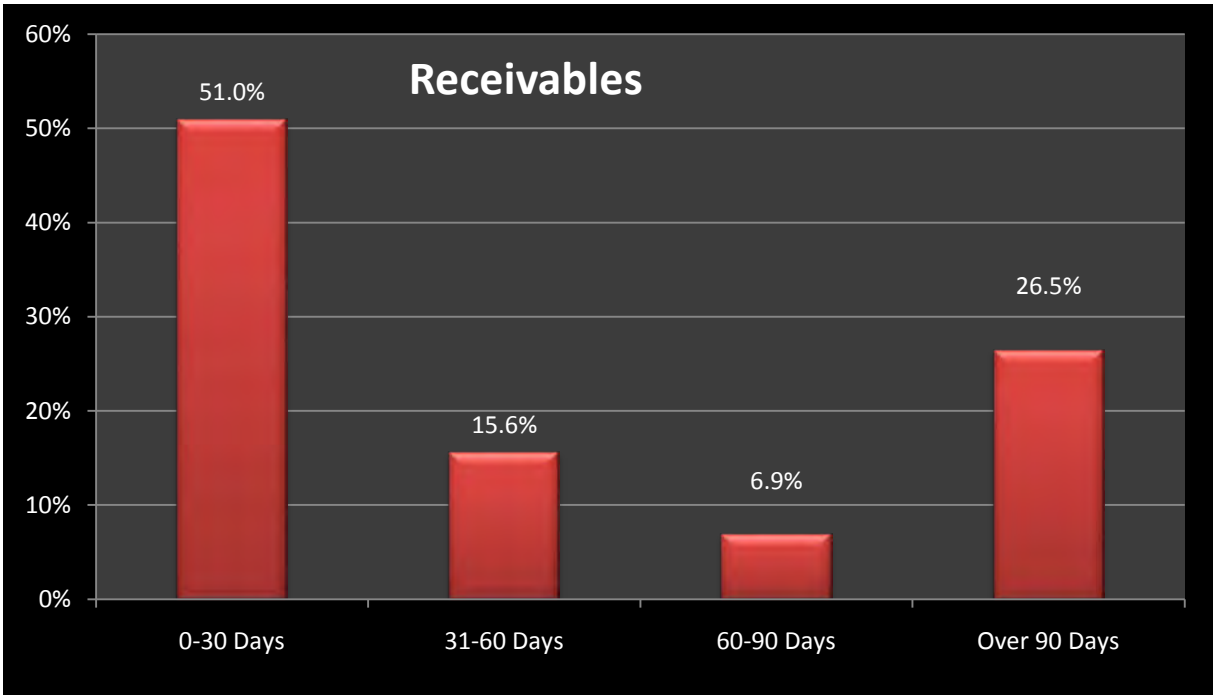
This report is based on a survey of Missouri hospitals, focused inquiries with hospitals, insurers and other interested stakeholders, and research of the secondary literature.[2] Because data were collected pursuant to the examination and investigation authority of the DIFP, all individual responses are considered confidential. Survey results are presented only in aggregate or in a form that otherwise preserves the anonymity of both respondents and insurers.

[1] Missouri DIFP A&H Supplement Data and Financial Annual Statement for Health. This figure approximates payments for health insurance coverage that is subject to Missouri's prompt pay statute. Workers compensation and medical payments made pursuant to liability coverage are not included in the $10.4 billion amount, nor are payments made by self-insured plans.

[2] Data preparation and analysis was overseen by Brent Kabler, Ph.D. of the DIFP's Statistics Section.

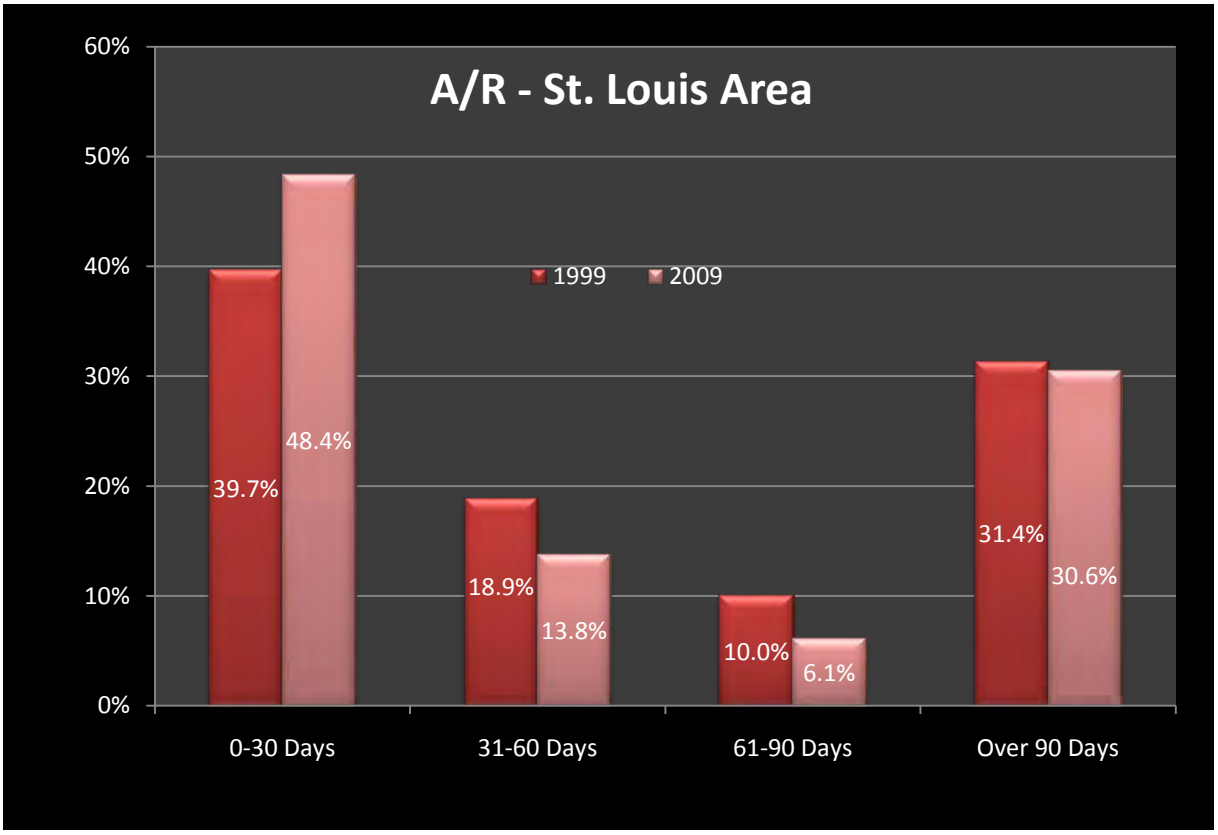
The survey response rate was substantial, with the 69 hospitals that provided data representing over 70 percent of hospital revenue in Missouri. In addition, several physician groups and clinics also provided data. Based on the survey results, it may be concluded that:

1. A significant proportion of pending claims (i.e. "accounts receivable" or A/R) submitted to insurers for medical services rendered remained unpaid in excess of 90 days. At the end of the 2nd quarter of 2009, hospitals and other providers that responded to the survey had outstanding claims equal to $584,705,541. Of this amount, over one-quarter, or $153,325,840, remained unpaid in excess of 90 days.[3] All A/R percents in this report are based on the dollar amount of claims rather than the number of claims. Claim numbers were requested, but most respondents were unable to provide these data.



[3] Note that these figures do not measure the percent of all claims paid in excess of 90 days. Since the A/R amounts are reported as of a moment in time, the "over 90 day" category represents the accumulated values of claims over time until such claims are either paid or "written off." The other time intervals, such as "under 30 days," will obviously not accumulate over time. The A/R data was collected since it was not possible for most hospitals to provide an accounting of all claims over a given time period. However, the A/R figures provide valuable information about the impact of timeliness of payment on hospitals' cash flow and finances, and are commonly used for this purpose.

2. A comparison of the 2009 data with comparable data from 1999 reveals that prompt pay standards enacted in 2001 have had a very modest impact upon the timeliness of claim processing. While the percent of claim amounts paid in under 30 days improved somewhat, the percent of claims still outstanding after 90 days remained virtually unchanged. The current Missouri prompt pay statute was effective in 2002.



Note: Data from the 1999 MHA survey was available only for the St. Louis area. For purposes of comparison, data from the 2009 survey was matched as closely as possible to the available 1999 data.

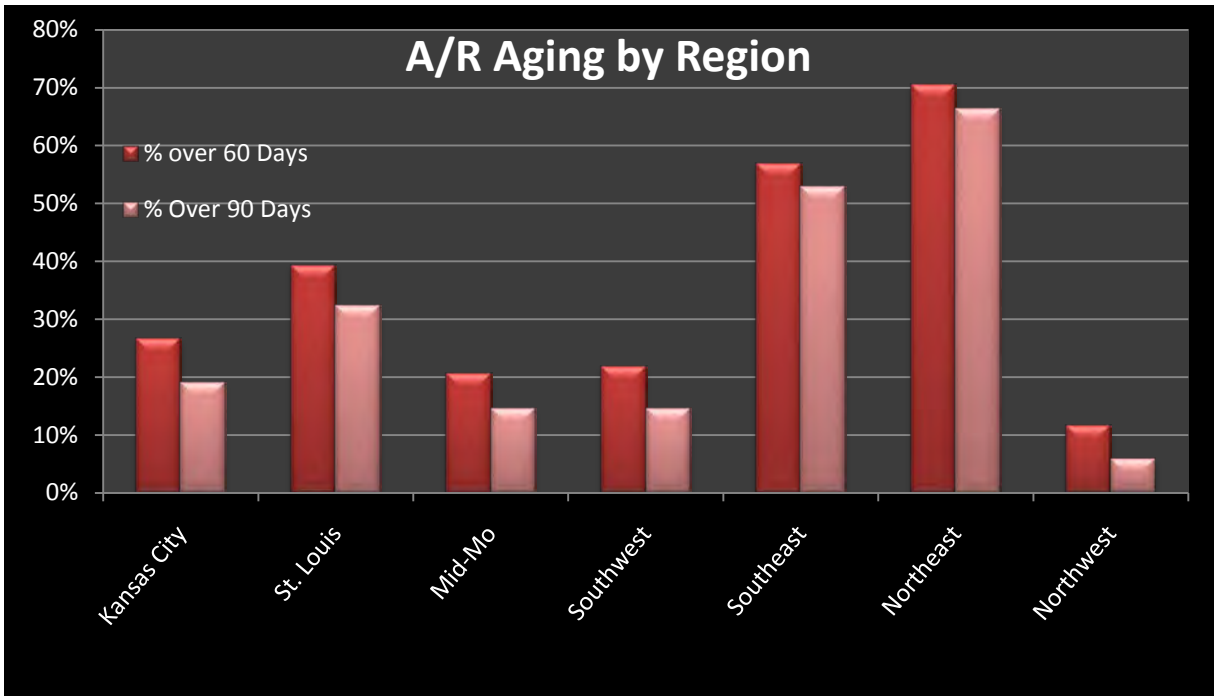
3. There is significant variation between insurers with respect to the timeliness of payments. For three insurer groups, nearly one-third of outstanding claims remained unpaid after 90 days, while the corresponding figure for the three most prompt payers was close to 10 percent.

Insurer Group	**% A/R Over 90 Days**	**Total A/R Amount***
J	31.3%	Less than $1M
D	30.5%	$10M to $20M
K	30.4%	$21M to $50M
G	29.2%	Over $50M
M	25.0%	Over $50M
C	24.8%	Over $50M
H	23.9%	Over $50M
N	23.9%	$10M to $20M
F	22.4%	$21M to $50M
I	18.6%	$21M to $50M
A	11.2%	Less than $1M
E	10.2%	$10M to $20M
L	7.4%	Less than $1M
Total	**26.5%**	**$581,008,538**

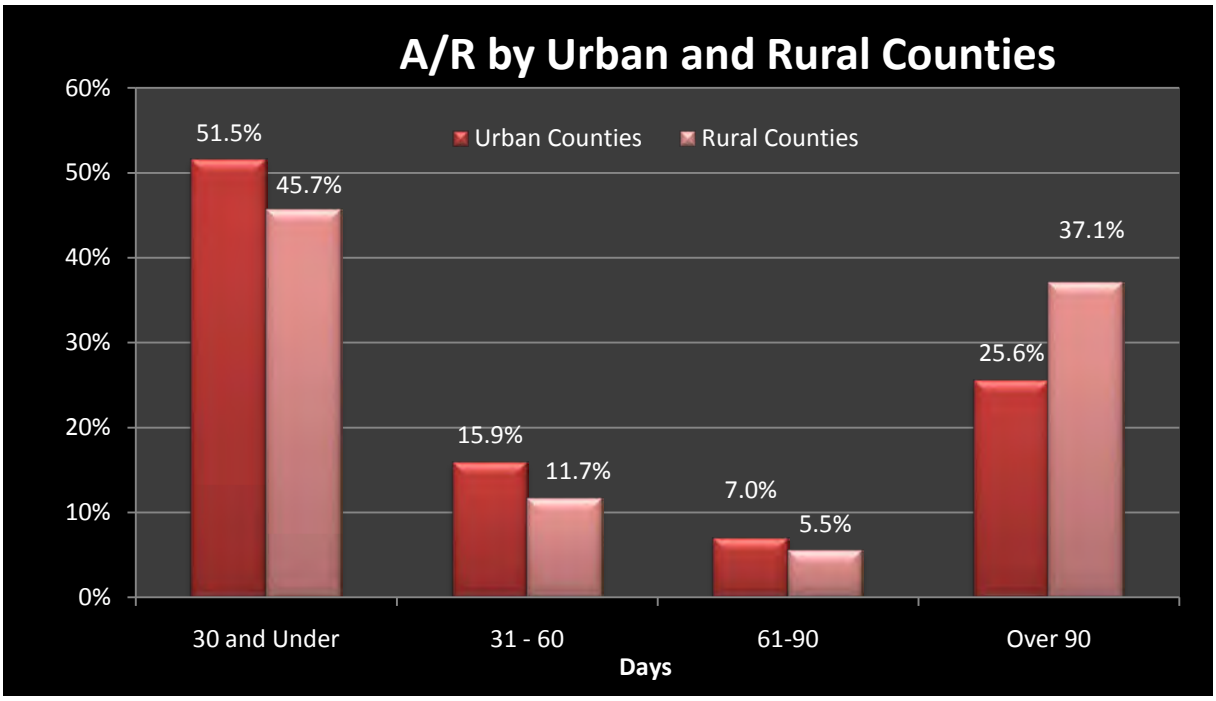
*A/R amounts in this column represent total A/R across all time categories: 0-30 days, 31-60 days, 61-90 days, and over 90 days.

The DIFP's Division of Insurance Market Regulation will continue investigating particular insurers to determine possible causes for the divergence across insurers, and consider all appropriate regulatory responses.

4. There was also significant variation across Missouri regions. In general, payment times were shorter for the western and middle areas of the state compared to eastern areas. Not all of the variation is attributable to a different mix of payers in each region, as there were also intra-payer regional differences. It is not known whether observed differences represent insurer practices that might have a regional impact or whether the differences are a result of hospital accounting practices, or both. The geographic regions are defined in the body of the report.



In addition, rural hospitals experienced significantly elevated delays compared to their urban counterparts. The proportion of claims still pending after 90 days (based on dollars) was 11.5 percentage points higher among rural areas of the state.



5. Services considered not medically necessary by the insurer ranked as the most common reason for claim denials. This reason alone accounted for over 44 percent of all denials (based on dollar amount). The second most common reason was a failure to meet claim submission deadlines, either with respect to the original claim or with requested follow-up information.

The analysis presented below suggests the need for unambiguous statutory guidelines governing claims processing. Missouri's current "prompt pay" statute became effective in 2002. Sections 376.383 and 376.384, RSMo, Supp. 2008,[4] establish timelines for processing health insurance claims, and violations are subject to interest and civil penalties. However, stakeholders have long expressed dissatisfaction with the current language, asserting that the statute has done little to improve claim processing delays. The survey results presented here provide some support to such contentions.

This report does not endorse particular statutory language, though deficiencies in the current statute are noted. It is the recommendation of this report that future legislative action be guided by the following principles:

Reasonableness: The information required by insurers to process a claim should be reasonably available to medical providers. For example, insurers should not be able to require patient tax returns or police reports.

Relevancy: Informational requests should be limited to items which are reasonably necessary to properly adjudicate a claim.

Transparency: All insurer informational requirements should be easily accessible to medical providers.

[4] All statutory references in this report are to the 2008 supplement of the revised statutes of Missouri unless otherwise indicated.

The following statutory deficiencies in current Missouri law have been identified:

1. Lack of a *clean claim* definition. About half of prompt pay statutes in other states provide a definition of clean claim. A clean claim is generally free from material defect or error and meets minimal informational standards. A claim not considered *clean* thus contains information that is incomplete, inaccurate or otherwise inadequate for an insurer to properly assess their liability. In the context of a prompt pay statute, a claim satisfying the legal definition triggers time limits for closing (i.e. paying or denying) a claim. Examples of clean claim definitions found in existing prompt pay laws can be found in the appendices. Definitions range from the relative generic Medicare standard to much more detailed definitions that specify forms and data elements.

2. The ability of insurers to *suspend* a claim indefinitely. Currently, insurers are required to pay, deny, or suspend a claim within forty days after receipt of the claim and any additional information deemed necessary to process the claim. An insurer may suspend a claim by "…giving notice to the claimant specifying the reason the claim is not yet paid, including but not limited to grounds as listed in the contract between the claimant and the health carrier…" §376.383.1(8) This provision appears to be unique to Missouri, and was originally included to afford insurers additional time to investigate unusual or suspect claims, such as instances of suspected fraud. However, medical providers claim that this provision of the statute can be implemented in an arbitrary way and places large volumes of claims in a sort of legal purgatory in which payments may be deferred indefinitely. As an alternative, some providers have suggested the abolition of the "suspension" clause so that a claim must either be paid or denied within the appropriate timeframes.

3. The lack of a consistent *processing days* standard for claims processing times. Currently, *processing days* is defined as "…the number of days the health carrier has the claim in its possession [excluding] days in which the health carrier is waiting for a response to a request for additional information." §376.383.1(6) However, this standard is not used consistently throughout the statute, so that in parts the terms *working days* or just *days* are substituted. As

written, the statute penalizes insurers for claim delays caused by the failure of medical providers to submit requested information.

Lastly, the Department of Insurance, Financial Institutions & Professional Registration (DIFP) is considering a heightened level of regulatory scrutiny of health insurers' claims processing practices. Since the prompt pay law became effective, the DIFP has recovered $2.1 million in unpaid interest, and assessed an additional $1.4 million in penalties for prompt pay violations found during market conduct examinations. In addition, investigations by the Consumer Services Section of complaints from medical providers regarding claims has resulted in recoveries totaling $1.7 million; $1.2 million of this amount was associated with claim processing delays. Under consideration are methods to increase market surveillance capacities to identify problem areas, and ways to exert an appropriate level of oversight.

The DIFP's Division of Insurance Market Regulation will be continuing the investigation initiated for this report to determine if examinations of particular insurers are appropriate. Pursuant to regulation, market conduct examination warrants may be issued if evidence indicates that an insurer may be "…engaging in any practice or course of business in violation…" of statute or regulation. Such evidence may be obtained from a variety of sources, including "market surveys" or "…any credible source with direct access to relevant information" (20 CSR 100.8.005(2)(C)(1 and 4)). The extent of claim processing delays, and the large variation in claims processing observed across insurers, may be indicative of possible compliance failures.

Overview

During the late 1990's numerous states enacted prompt pay statutes in response to complaints by medical providers about the timeliness of payments by health insurers. Prompt pay statutes should, at a minimum, establish clear time frames for closing a claim. Missouri's prompt pay statute became effective in 2002. Since then, the DIFP has levied $3.4 million in interest and penalties for significant violations of the statute. However, many medical providers, in both Missouri and elsewhere, argue that prompt pay statutes have had little practical impact on overall claims handling, and assert that a large volume of claims remain unpaid well in excess of statutory timeframes.

While large medical institutions may be able to weather cash flow problems stemming from untimely payments, the ability of smaller provider groups and physician practices to effectively deliver medical services could be significantly impaired if claims are not paid in a timely fashion. Like all businesses, medical providers depend on relatively prompt debt satisfaction in order to maintain payroll, make necessary capital investments, and generally "pay the bills."

Due to the concern that the delivery of essential medical services might be impaired, Governor Jeremiah W. (Jay) Nixon issued Executive Order 09-24, establishing the Prompt Pay for a Healthy Missouri Project ("the Project") to inquire into the claims handling practices of Missouri health insurers. This report is the result.

Methodology

In addition to conducting focused discussions with various stakeholders and researching secondary sources, a survey of Missouri hospitals was issued to try to capture a "snapshot" of accounts receivable, or A/R. The A/R figures represent claims currently pending as of the end of the second quarter of 2009. In some ways, A/R data are a somewhat circumscribed representation of claims handling practices. This method was chosen since most hospitals would

have significant difficulty providing a census of all claims processed during a specified time period, while the A/R figures are routinely produced by most institutions and are generally considered an appropriate measure of the revenue cycle or cash flow. Thus, the A/R amounts could be reliably produced within the relatively short time period allotted for the survey and subsequent report. In addition, the DIFP sought information about the causes of claim delays and denials, though only about half of respondents were able to satisfy this request.

It is worth noting that respondents were generally unable to provide data consisting solely of licensed insurers, such that self-insured health plans that do not fall under the purview of the prompt pay statute are included in the figures presented below. To the degree that self-insured plans have significantly lengthier claims processing times compared to licensed insurers, the figures below may somewhat overestimate claim delays by licensed carriers. Several insurers have indicated that this is indeed the case. However, beyond anecdotal evidence, no empirical data were available to assess the accuracy of such claims nor to quantify the magnitude of any possible "statistical bias" arising from the inclusion of self-insured business.[5]

Respondents were asked to produce A/R reports for each of several large Missouri insurers. Insurers were selected based on 2008 premium written for comprehensive health coverage (excluding, for example, long term care policies or credit accident & health), The list of carriers contains life companies and HMOs. Property and casualty companies, and associated lines of business such as workers compensation or medical payments made pursuant to liability policies, were excluded. Respondents were also asked to provide data only for payments owed by specified insurers, exclusive of any co-pays or other amounts due from patients.

With the assistance of the Missouri Hospital Association, a questionnaire was emailed to virtually all licensed hospitals in Missouri. In addition, the survey questionnaire was placed on the DIFP's website and information from medical providers other than licensed hospitals, such as physician groups or clinics, was solicited. A/R aging reports by insurer were requested, with the

[5] Providers generally do not know whether an patient is covered under a fully insured plan or whether the insurer is acting as a "third party administrator" to a self-insured plan. Beginning in 2010, insurers will be required to distinguish fully insured from self-insured coverage on each identification card issued to insureds (20 CSR 100-1.070). The inability of providers to distinguish each type of coverage has historically limited the ability of providers to exert their legal rights under Missouri's prompt pay statute.

data captured in four categories consisting of all open claims that were pending 0-30 days, 31-60 days, 61-90 days, and over 90 days as of the end of the second quarter of 2009. In addition, providers were asked to detail the reasons claims were denied and ultimately written-off. Again, the survey was designed to capture useful information within the context of time constraints, given the degree of urgency surrounding prompt pay issues.

Non-respondents were contacted a second time, resulting in a significantly improved response rate. The final response rate was rather high compared to the general experience of mail surveys. Nearly half of licensed hospitals submitted data, though the respondents represented 71 percent of all hospital revenue in Missouri. In addition, several large physician groups and clinics provided data.

In the analysis that follows, data are presented by Missouri regions (defined below). While the overall response rate supports robust inferences, responses rates were substantially lower in some areas of the state. As a caveat, conclusions about regions with low response rates should be considered somewhat provisional. The regional response distribution is as follows:

Table 1a: Survey Response Rate by Region

Region	**Market Share of Respondents, Based on Total Annual Revenue from All Sources**
Kansas City and surrounding area	63.9%
St. Louis area and surrounding	88.5%
Mid-state	78.1%
Southwest	85.5%
Southeast	8.1%
Northeast	62.3%
Northwest	15.6%
Total	**71.0%**

Data are also presented separately for urban and rural counties. The response rate for rural hospitals was significantly lower than that for urban hospitals.

Table 1b: Survey Response Rate by Level of Urbanization	
Region	**Market Share of Respondents, Based on Total Annual Revenue from All Sources**
Urban counties	82.6%
Rural counties	38.4%

Background – Financial Stress in a Period of Economic Uncertainty

Many businesses rely to some degree on the day-to-day extension of credit to their customers for the provision of goods and services. Obviously, the financial viability of a business can be impaired if a large proportion of accounts remains unpaid for significant periods of time, or must ultimately be written-off as uncollectible. Health care providers are almost unique among industries in that virtually all services are rendered on "credit," such that payment for services delivered today will occur at some future date. Only a small fraction of medical services are paid for "up front."

Along with administrative costs associated with claims processing, payment delays *per se* can impose significant costs upon medical providers - the present value of amounts ultimately paid after significant delays may be substantially less than the nominal value of claims.[6] One study found present value losses due to claim delays to be nontrivial. Based on an analysis of

[6] That is, economists recognize that monies received in the present are more valuable in real terms than monies received in the future. To account for the time value of money, *present values* are calculated by discounting nominal monetary amounts by some rate over time, commonly the interest rate.

claims delayed beyond permissible statutory guidelines, the value of the payments declined by 6 percent in real terms compared to the value of claims paid in conformity to statute.[7]

Beyond the erosion of present values attributable to claim delays, simple administrative costs associated with processing claims can be substantial. One study of hospital and physician offices in California estimated that physician offices spent up to 14 percent of revenue on the insurance and billing function; the corresponding figure for hospitals was 7-11 percent.[8]

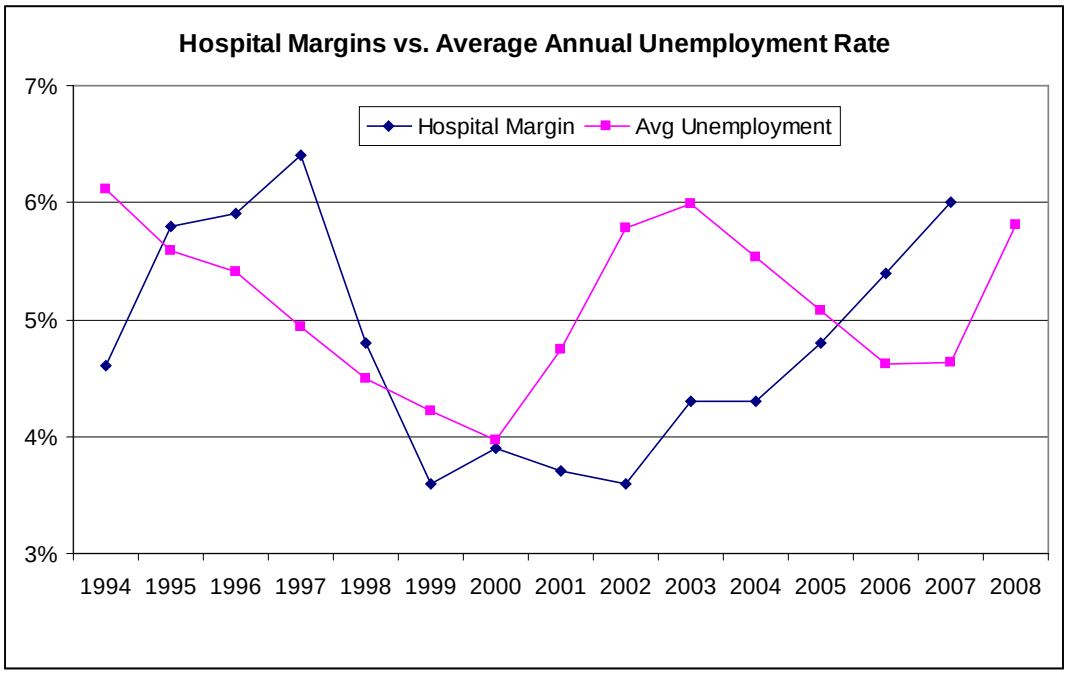
During periods of robust economic growth, medical providers and particularly larger institutions are better able to absorb the costs associated with even substantial delays in compensation associated with claims processing. Medical institutions receive a substantial proportion of revenue from non-patient sources, such as investment income. However, such revenue streams as well as costs may fluctuate significantly in conjunction with the economic business cycle. In addition, increases in indigent care and loss of patient volume can impair financial performance and operating margins during economic downturns. During such times, timely payment may assume a more critical role in the financial health of medical providers and their continued ability to deliver necessary services.

The relationship between hospital margins (or the ratio of revenue to costs) and the economic business cycle is apparent in the following figure. Using the unemployment rate as a proxy for economic growth, the following graph illustrates how operating margins are inversely related to general economic conditions. When unemployment increases, operating margins generally decrease, though the period 1998-2000 appears to be an exception. As unemployment rates declined after the recession ending in 2003, operating margins quickly recovered.

[7] Swayne, Lawrence, et al. 2002. Compliance with prompt payment legislation: The initial experiences of New Jersey Radiologists. **American Journal of Roentgenology.** 179: 21-25.

[8] Kahn, James G, et al. 2005. The cost of health insurance administration in California: Estimates for insurers, physicians, and hospitals. **Health Affairs.** 24: 1629-1639.

Figure 1



Source: Unemployment data from the Bureau of Labor Statistics. Hospital operating margin data were obtained from Medicare Payment Advisory Committee (MPAC). June, 2009. *A Data Book: Healthcare Spending and the Medicare Program.* Washington: Government Printing Office, page 84.

Table 2

Hospital Margins and Average Annual Unemployment		
Year	Hospital Margins - All Payers	Avg. Annual Unemployment
1994	4.6%	6.1%
1995	5.8%	5.6%
1996	5.9%	5.4%
1997	6.4%	4.9%
1998	4.8%	4.5%
1999	3.6%	4.2%
2000	3.9%	4.0%
2001	3.7%	4.7%
2002	3.6%	5.8%
2003	4.3%	6.0%
2004	4.3%	5.5%
2005	4.8%	5.1%
2006	5.4%	4.6%
2007	6.0%	4.6%
2008	*	5.8%

Even during more prosperous times, smaller hospitals and physician practices may experience difficulty in building capacity or maintaining reserves. For example, during 2007 the operating margin of all hospitals was a robust 6 percent. However, during that same year, 25 percent of hospitals reported a negative margin such that they were essentially operating at a loss.[9]

While operating margin data are unavailable past 2007, it appears very likely that the current economic downturn is having a deleterious impact on the financial position of medical providers. Indeed, there is abundant evidence that financial indicators have significantly deteriorated since 2007. According to the Healthcare Financial Management Association (HFMA), by the end of 2008 hospitals faced "…unprecedented levels of financial impact from the economic recession and credit market dislocations." For example, fifty percent of hospitals reported declines in patient volume during the last half of 2008, and over 60 percent reported that increases in indigent care and bad debt were having a negative impact of financial performance. In a follow-up hospital survey conducted in March of 2009, 73 percent of respondents reported a decrease in cash on hand, with 22 percent reporting declines in excess of 20 percent.[10]

As the following figures attest, the impact of revenue strains differ by type of hospital. In general, larger hospitals with greater investment streams suffered the greatest declines in nonoperating income, while rural hospitals experienced the most significant declines in patient revenues. Among the largest hospitals with bed capacity over 500, 83 percent reported declines in nonoperating income, and 79 percent of such hospitals experienced declines of greater than 20 percent. Conversely, 60 percent of smaller rural hospitals reported declines in net patient revenue, with 39 percent of hospitals reporting revenue declines of over 5 percent.[11]

[9] MPAC, *op cit.*

[10] Healthcare Financial Management Association. June, 2009. *Healthcare Financial Pulse. Special Report: How Hospitals are Responding to the Current Financial Crisis.* Available on the internet at http://www.hfma.org/pulse/default.htm

[11] *Ibid.*

Figure 2a

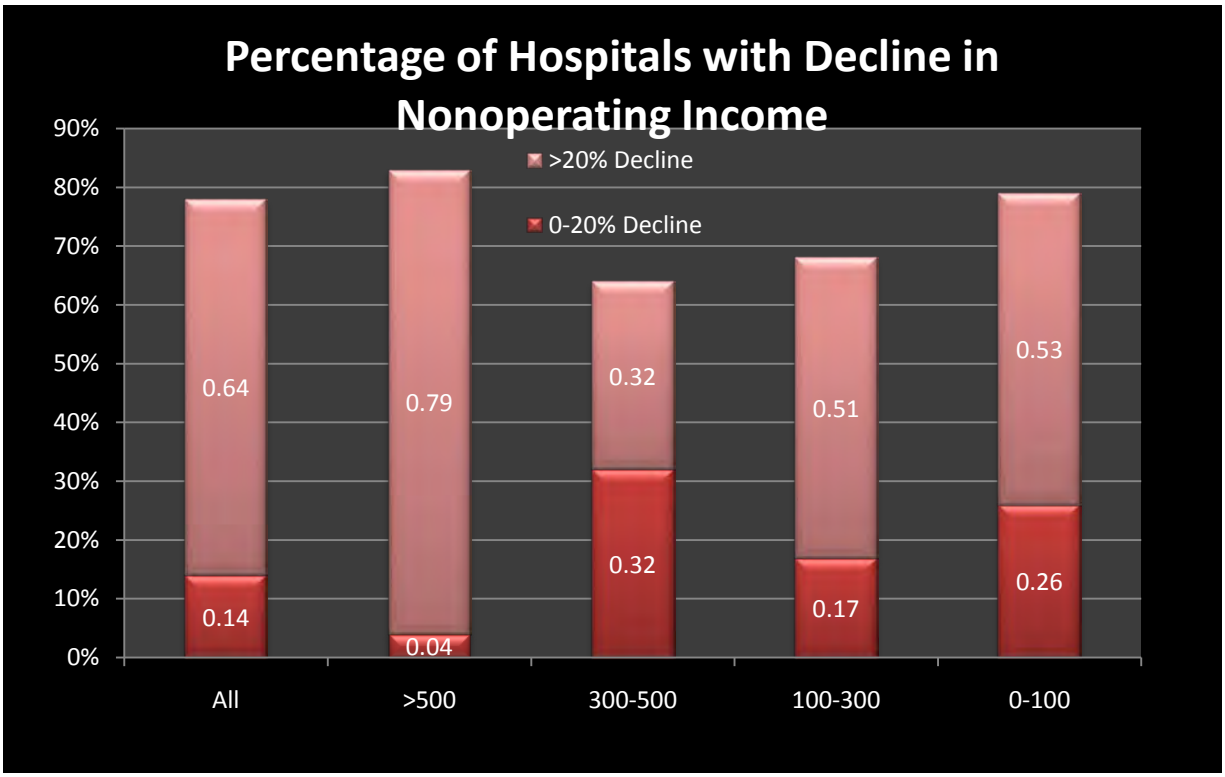
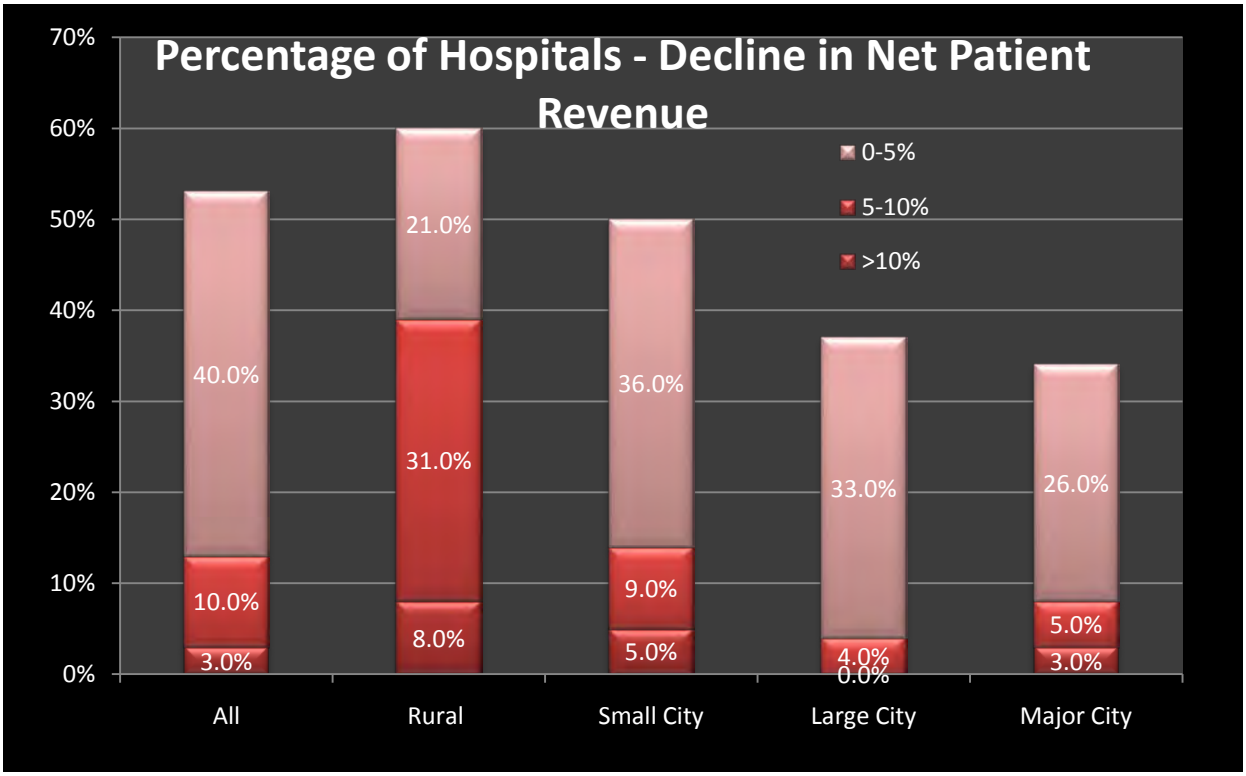


Figure 2b

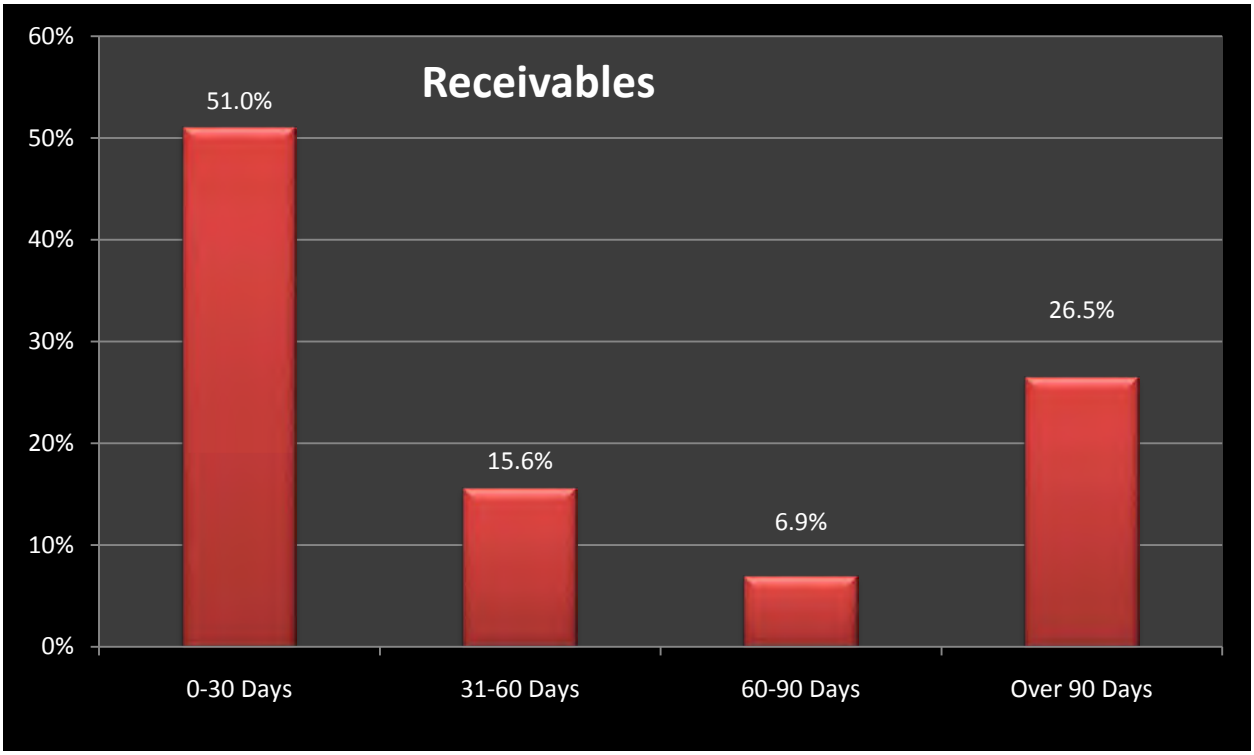


These figures indicate that, especially in times of economic stress, medical provider financial performance can be sensitive to the timeliness of claim payments. While no hard evidence has been found that might quantify the impact of claim delays on the ability of providers to deliver essential medical services, anecdotal evidence suggests that smaller hospitals and physician practices may experience significant cash flow problems that could impair such services. This issue deserves greater investigation than was possible in the relatively limited time frame allotted for producing the report. However, the evidence obtained suggests a cause for concern.

Survey Results

The survey reveals that outstanding accounts of medical providers are "aged" well beyond those of other industries. For all providers that responded to the survey, 26.5 percent of the dollar amount of claims in A/R were still pending after 90 days. Based on conversations with provider accounting staff, these claims are not written off and removed from A/R until such time as they are considered uncollectible.

Figure 3: A/R Aging Exhibit from 2009 Survey



Source: Prompt Pay Project, Survey of Missouri hospitals, 2009

The amounts of delayed payments are substantial. The dollar amount of claims remaining unpaid after 90 days totaled nearly $154 million. While this represents a relatively small proportion of total annual hospital revenue (approximately 1.4 percent), amounts associated with delayed claim payments are large in nominal terms. In addition, the A/R amount is a measurement at a single point in time. Annualized amounts are likely to be significantly larger.

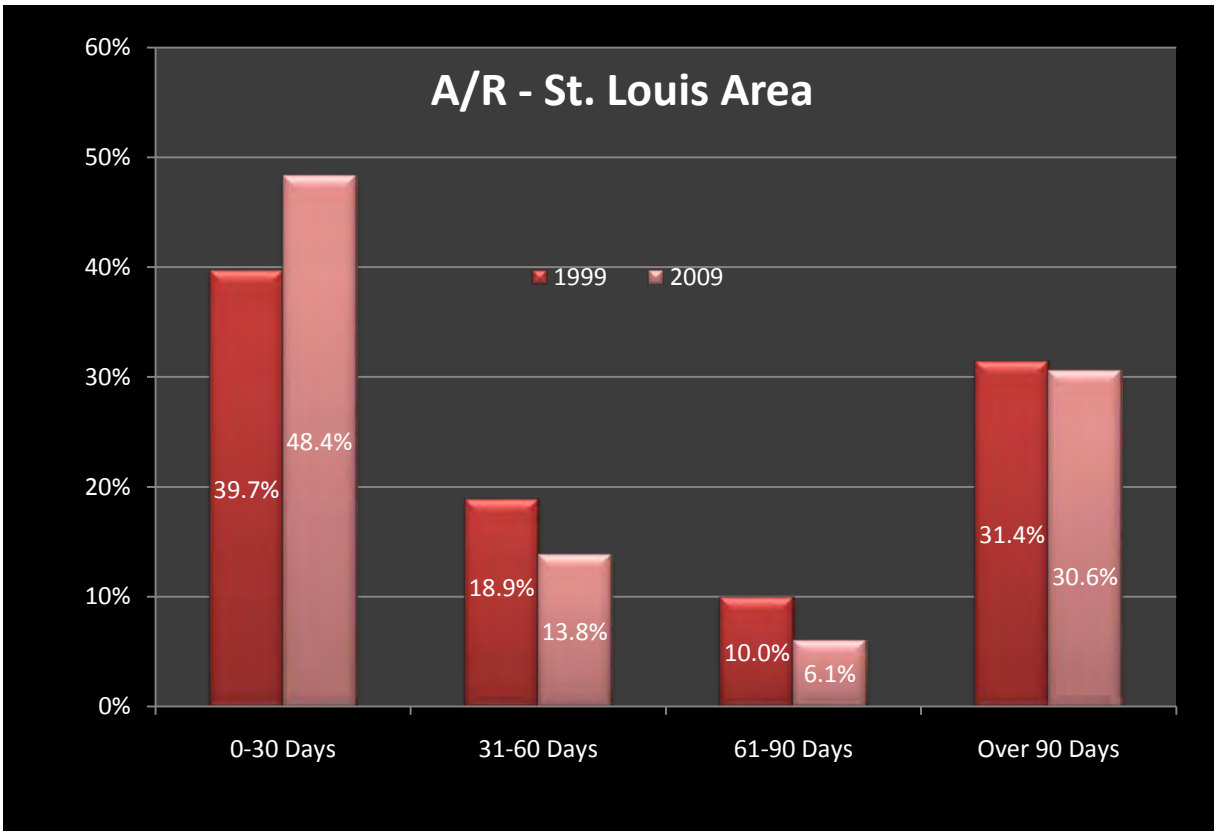
Comparison With 1999 Survey

The survey results indicate that the passage of Missouri's prompt pay law, effective in 2002, has had only a very modest impact on claims processing times, and virtually no impact on the roughly one-quarter of claims that take the longest to resolve. In 1999, the Missouri Hospital Association (MHA) conducted a more limited prompt pay survey of Missouri hospitals. Since both the 1999 and 2009 surveys used identical formats, the figures are directly comparable. The 1999 data therefore provide a "baseline" measure of A/R accounts prior to the effective date of prompt pay legislation.

The subset of the 2009 data was designed to match as closely as possible the respondent set of the MHA survey for the St. Louis area.[12] Both data points reflect the aging of A/R as of the second quarter. The comparison reveals some improvement in that a greater percentage of claims were paid in under 30 days in 2009 compared to ten years previously, or 39.7 percent vs. 48.4 percent. However, the amounts represented in the *over 90 days* category remained virtually unchanged. In 1999, 31.4 percent of claim amounts remained unpaid after 90 days. In 2009, the figure declined only very slightly to 30.6 percent.

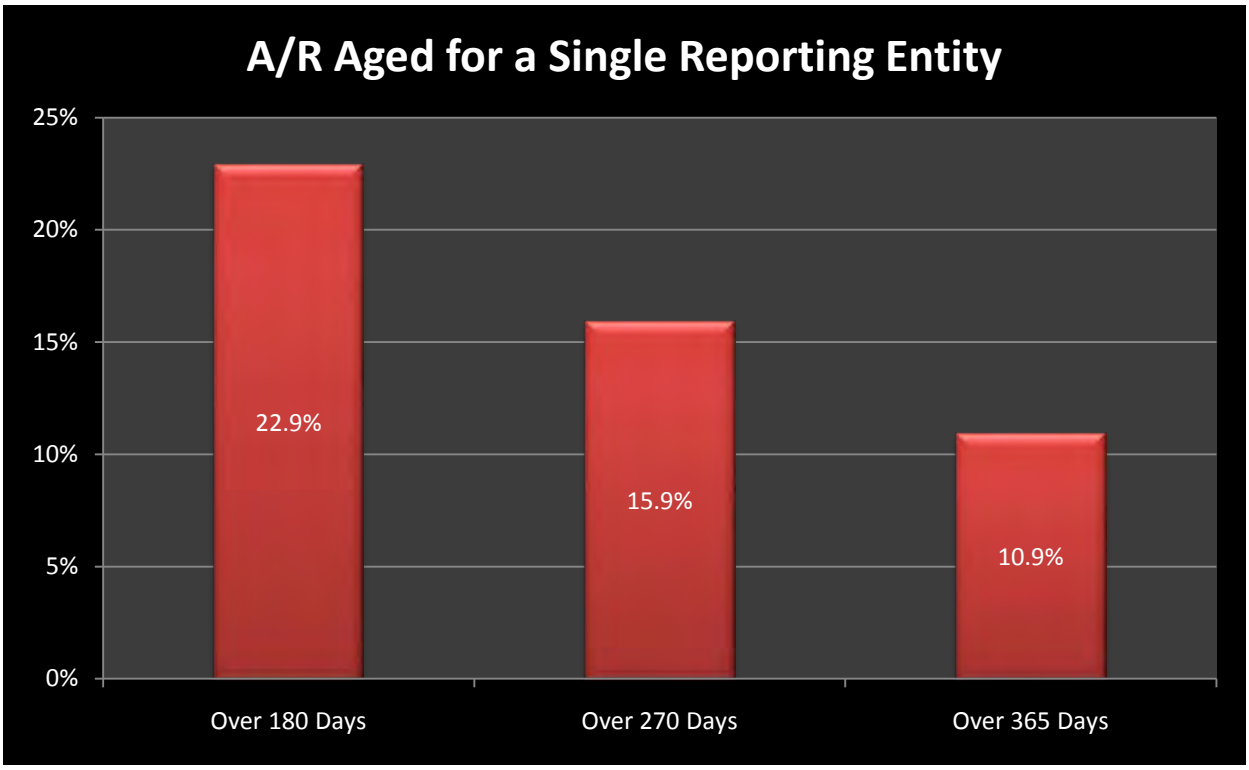
[12] At the time of writing, 1999 data were available only for selected hospitals located in the St. Louis area.

Figure 4: Comparison of 1999 and 2009 Survey Results



The DIFP was able to obtain more detailed claims aging information from one survey respondent. For this entity, as of October 2009, over 50 percent of outstanding claim amounts had been pending beyond the statutory payment standard of 45 days, and over 10 percent remained unpaid for over a year.

Figure 5



The Missouri results do not vary substantially from the findings of other studies. For example, data from ambulatory surgical centers reveal that 24.5 percent of A/R amounts had aged to over 90 days, and 16.1 percent had remained unresolved after 120 days.

Table 3

Ambulatory Surgical Centers	
Percent A/R by Days Pending	
0-30 Days	49.4%
31-60	19.7%
61-90	9.0%
91-120	6.4%
121+	16.1%
Percent over 90 Days: 24.5 percent.	

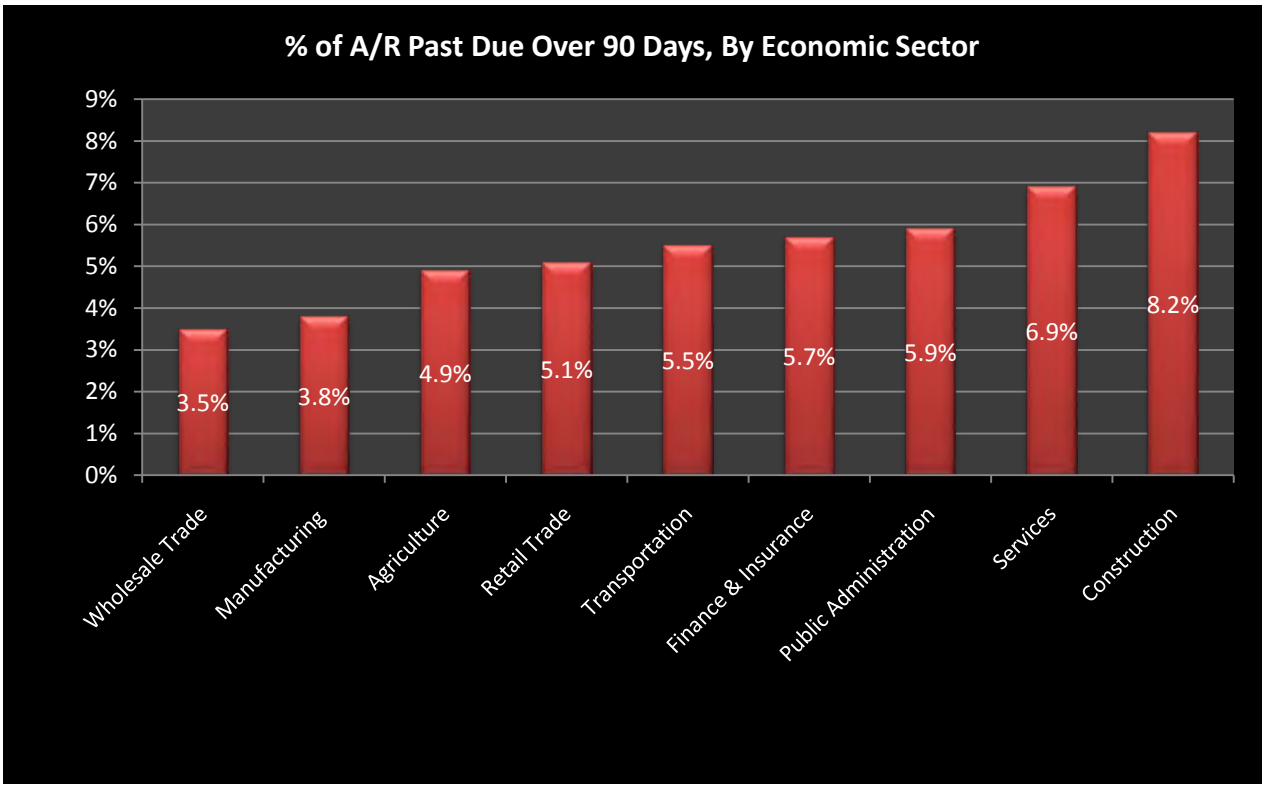
Source: Becker's ASC Review. December 9, 2008.

The financing of medical services differs from the production of goods and services in most other industries. Medical claims are complex, often involving coordination issues between payers, complicated contractual issues and coverage questions, and differences of opinion regarding appropriate care. The adjudication of claims can at times be labor and time intensive and requires a significant amount of detailed medical and financial information. It is not necessarily unreasonable to expect that some volume of claims will remain unresolved for lengthy periods of time.

However, it is useful to compare the aging of A/R to other industries to provide some context to the revenue cycle that many medical providers confront. According to the private firm Cortera, 5.7 percent of A/R amounts across all industries were over 90 days past due. The comparable figure for Missouri businesses was 4.2 percent.[13] Amounts across different industrial sectors are presented in the following chart, and range from 3.5 percent for the wholesale trades to 8.2 percent for construction firms. Hence, the age of medical providers' A/R well exceeds other economic sectors. While the causes of claim delays are not entirely clear, it appears that the timeliness of payment is a broad problem shared by virtually all medical providers.

[13] Note that the figures are not entirely comparable to the survey data. The Cortera data assess amounts *past due*. The survey data do not possess a *past due* category, since claims generally have no due date beyond the time parameters defined in statute.

Figure 6



Missouri Average: 4.2%
US Average: 5.7%
Source: Cortera, August, 2009. *Accounts Receivable Industry Metrics and Stats.* Available on the internet at http://www.cortera.com/stats/.

Other Indicators

The survey data indicate that claim delays are broad in scope. This conclusion is supported by additional data associated with the DIFPs enforcement of Missouri's prompt pay statute. Enforcement has assumed two forms: market conduct examinations of select insurers and investigations conducted in response to consumer or provider complaints.

In 2003, the department closed a series of examinations targeting possible violations of the prompt payment statute. Missouri statute establishes a standard that 95 percent of claims must be resolved in conformity with statutory guidelines, thereby recognizing that a small

proportion of claims may be exceptional to the degree that additional processing time is required. As a result of these examinations $3.5 million in interest and penalties were levied against insurers. The DIFP has made additional recoveries related to prompt pay violations during subsequent examinations, though the amounts have not been tracked.

In addition, the department actively investigates individual complaints lodged by medical providers against insurers they believed had unfairly denied or delayed claims. Consumer related investigations are more limited in scope than market conduct examinations, and are confined to the particular circumstances of the complaint rather than the more general business practices of a company.[14] Between 2003 and mid-November 2009, the DIFP received a total of 1,577 complaints from medical providers about the manner in which insurers were processing claims. Subsequent investigation and enforcement resulted in the resolution of claims totaling $1.7 million, and $1.2 million of that amount was associated with claim processing delays. In 2009 alone, complaints about claims handling practices were resolved with $946,919 in payouts, of which $741,171 were associated with processing delays. This increase in the amount of recoveries represents the recent commitment by DIFP to more actively use its investigation authority to resolve prompt pay complaints. Since the beginning in 2009, all complaints from medical providers have been forwarded to the Consumer Services Section for investigation.

[14] Inferences about general business practices are supportable only via broad examination of a carrier's files. For example, random sampling across many insureds can support more generalized inferences. Complaint investigation are usually confined to a specific individual complainant, though complaint activity can trigger more comprehensive regulatory action.

Table 4: A&H Complaints from Medical Providers

Table 4a Provider Complaints Reported

Complaint Type	2003	2004	2005	2006	2007	2008	2009 (Through mid-November)	2005-2009
Provider complaints to consumer services (claims related)	34	30	54	35	50	167	298	668
Prompt pay complaints to market conduct (through March, 2008)	117	109	223	196	224	40	0	909
Total provider complaints	151	139	277	231	274	207	298	1,577

Table 4b Provider Complaints Closed With Recovery

Complaint Type	2003	2004	2005	2006	2007	2008	2009 (Through mid-November)	2005-2009
All claims related	11	17	24	19	26	75	120	292
Prompt Pay or Delay Issues	3	9	8	7	7	24	51	109

Table 4c Provider Complaints Amounts Recovered

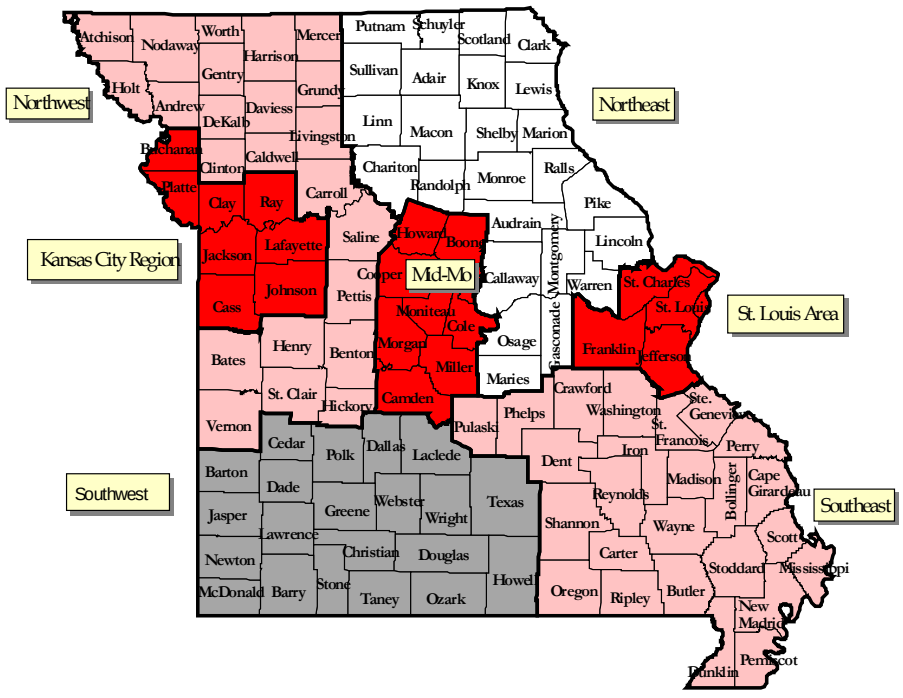
Complaint Type	2003	2004	2005	2006	2007	2008	2009 (Through mid-November)	2005-2009
Claims Related	$6,756	$15,133	$19,151	$67,088	$50,597	$635,689	$946,919	$1,741,332
Prompt Pay or Delay Issues	$2,769	$10,564	$2,244	$3,277	$6,231	$470,217	$741,171	$1,236,473

Regional Differences

The survey results reveal large variations between Missouri regions. The percentage of claim amounts in A/R in excess of 90 days ranged from approximately 10 percent to 70 percent. In general, there appeared to be an east/west divide, so that the Kansas City, mid-Missouri and southwest regions evinced shorter payment times compared to the St. Louis and eastern regions.

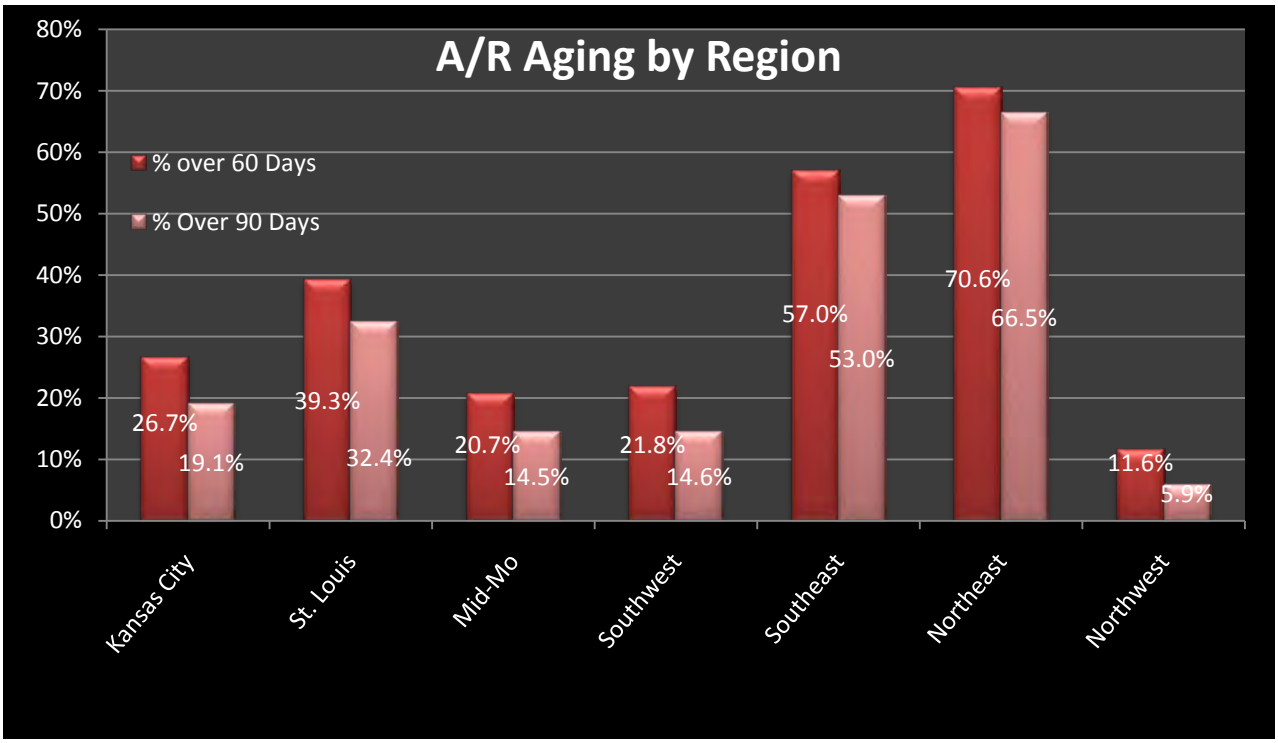
To assess regional disparities, Missouri was divided into seven regions based loosely on metropolitan statistical areas (MSAs) as defined by the Bureau of the Census, supplemented with further refinements to more rural counties.

Figure 7: Missouri Regions



These regions vary substantially not only by demographic characteristics, but are also characterized by dominant regional healthcare provider groups and insurers. Differences in claims processing times could be attributable to any or all of these factors. For example, different accounting systems or financial management strategies of hospitals could be partially responsible for regional differences. Similarly, because different regions are dominated by different insurer groups, part of the observed differences might be attributable to claims processing on the part of different payers. Demographic factors might also be partially responsible.

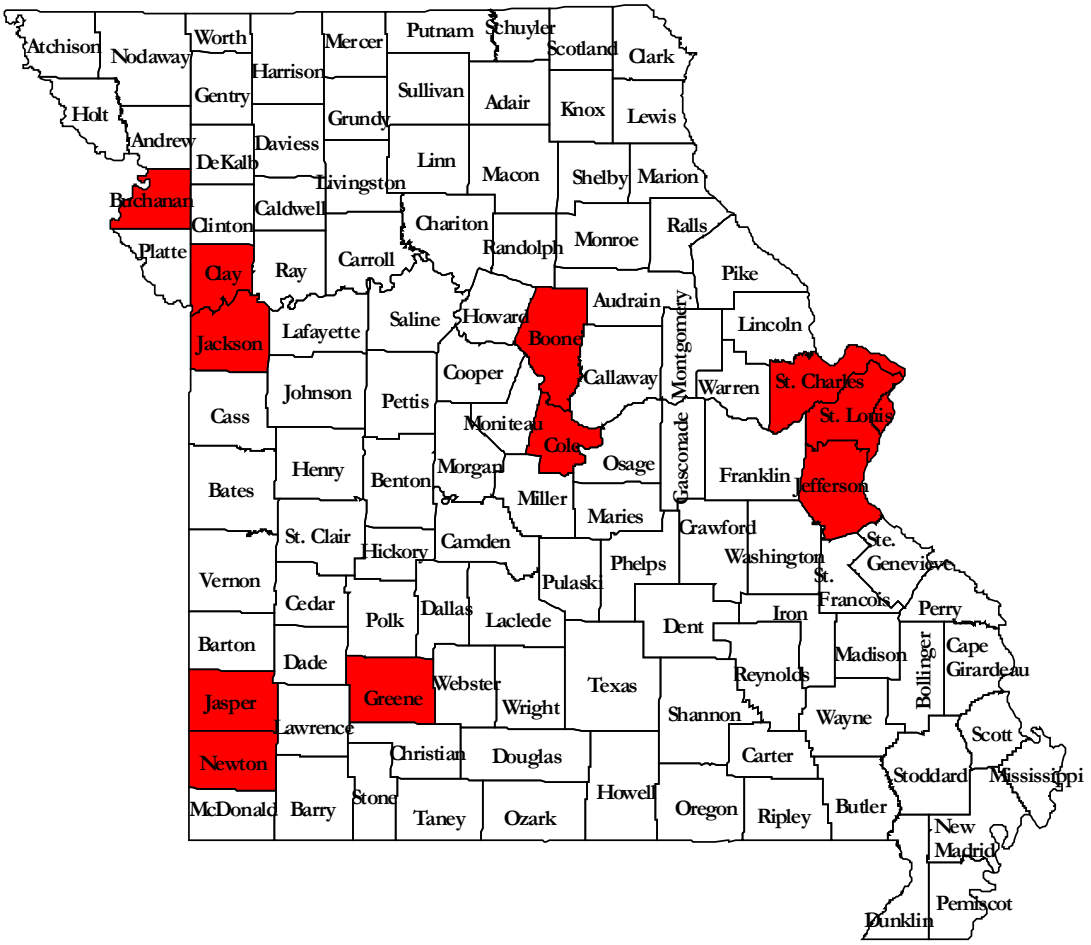
Figure 8



Of particular concern is how untimely payments may impact smaller rural hospitals that are less able to weather cash flow interruptions. The US Census Bureau classifies urban clusters based on population density. Urban areas can include contiguous regions with population

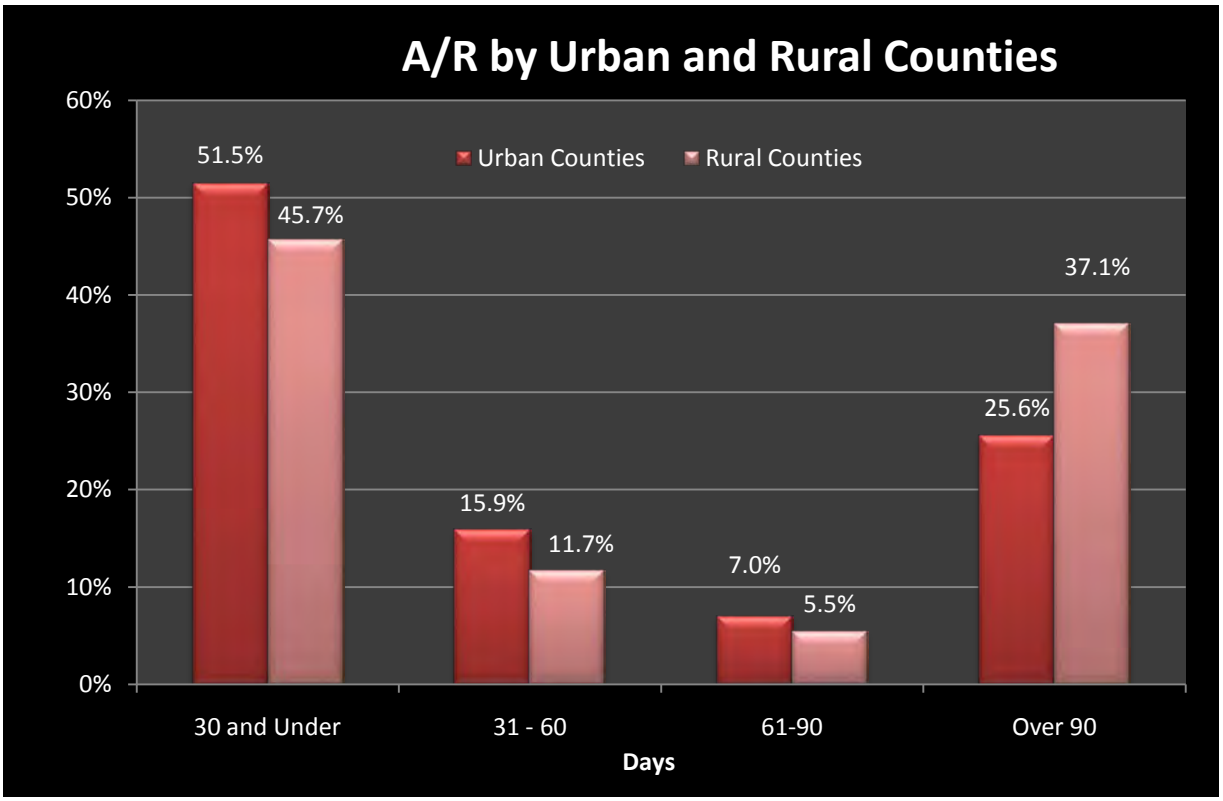
densities below the population density threshold in some circumstances. The shaded counties below are classified as urban.

Figure 9: Map of Urban and Rural Counties



Rural hospitals reported a significantly greater percentage of A/R amounts pending for over 90 days than did hopsitals located in urban counties. While urban providers reported a percentage A/R over 90 days very close to the statewide average, rural hospitals reported an amount 11.5 percentage points higher.

Figure 10



Variation Across Insurers

Significant differences in the timeliness of payment were also observed across insurer groups. Insurer groups have been randomly assigned an alphabetic code (A – N) in the following table. The size of each insurer group is identified only in a general way to minimize the possibility that end users could determine their identities from generally available market share data. Since the data were collected pursuant to the DIFP's investigatory authority, individual responses are considered confidential. In addition, releasing the identities of insurers could compromise the identities of responding medical providers. Since both insurers and hospital groups tend to be regional, knowledge of an insurer could reveal information about providers that may have reported a disproportionate share of each insurer's data. General knowledge of insurer size is provided so that readers may assess the statistical credibility of the reported data. Results for smaller insurers may be subject to random distortions in the data.

Across all insurer groups, 26.5 percent of A/R amounts were pending in excess of 90 days. This figure ranged from approximately 10 percent for three insurer groups to over 30 percent for the three slowest payers. The median insurer group had an A/R over 90 days of 23.9 percent.

Table 5

Insurer Group*	% A/R Over 90 Days	Total A/R Amount
J	31.3%	Less than $1M
D	30.5%	$10M to $20M
K	30.4%	$21M to $50M
G	29.2%	Over $50M
M	25.0%	Over $50M
C	24.8%	Over $50M
H	23.9%	Over $50M
N	23.9%	$10M to $20M
F	22.4%	$21M to $50M
I	18.6%	$21M to $50M
A	11.2%	Less than $1M
E	10.2%	$10M to $20M
L	7.4%	Less than $1M
Total	**26.5%**	**$581,008,538**

*Insurer identities have not been disclosed in this report since the responses to the survey are considered confidential communications gathered under the investigation and examination authority of the Director of the Department of Insurance, Financial Institutions and Professional Registration pursuant to §§374.070 and 374.071.

It should be stressed that A/R aging data, by themselves, do not reveal violations of prompt payment statutes. However, the magnitude of such variations does constitute cause for concern. Along with information presented elsewhere in this report regarding the scope of timeliness issues, the data presented here suggests that heightened regulatory scrutiny of claims handling is warranted. Possible regulatory strategies, along with legislative changes, are discussed at the end of this report.

Possible Causes of Claim Processing Delays

The bulk of the data collected via the survey was designed to quantify the scope of claim processing delays, and assess the possible impact on the revenue cycles of Missouri hospitals. However, the survey also requested data on the causes of claim delays. Unfortunately, many survey respondents were unable to provide the detailed information requested. Prior to the survey, it was determined that medical providers were unable to directly quantify reasons for claims processing delays without a labor intensive manual inspection of each claim file. Since it was unlikely that medical providers would be able to devote staff to this project, the survey requested information about claims that were denied. It was believed that this subset of claims would consist of those that were most difficult to adjudicate, requiring the production and assessment of much more detailed and complex information than claims associated with more routine medical care. For this reason, data for denials should provide at least indirect evidence about the causes of claim delays. Approximately half of respondents were able to provide the requested data for denials.

Nearly 80 percent of denials can be attributed to only two causes. The largest body of claims (based on the size of claims) were denied based on *medical necessity*. Most insurer contracts permit the denial of payment of medical services that insurers' believe are medically unwarranted or unnecessary, that are considered experimental or outside the generally accepted standard of care, or that are considered excessive in relation to the condition being treated.

The second largest category of claim denials resulted from a failure to file claims or additional information requested by the insurer, within contractual time limits. Over one-third of claim denials were attributable to such untimely filings or provision of information. An additional 10 percent of payments were denied because the medical service was not a covered benefit under the insurance contract, or the patient was not a covered insured. The remainder of denials were due to coordination of benefits between insurers, PCP referral problems, and failure to obtain appropriate precertification for specific procedures or treatments.

The following are examples provided by medical providers of claims that were denied in whole or in part:

A physician ordered a procedure to be performed on Saturday, but due to staff scheduling the procedure wasn't performed until the following Monday. The insurer refused payment for the hospital stay for Sunday.

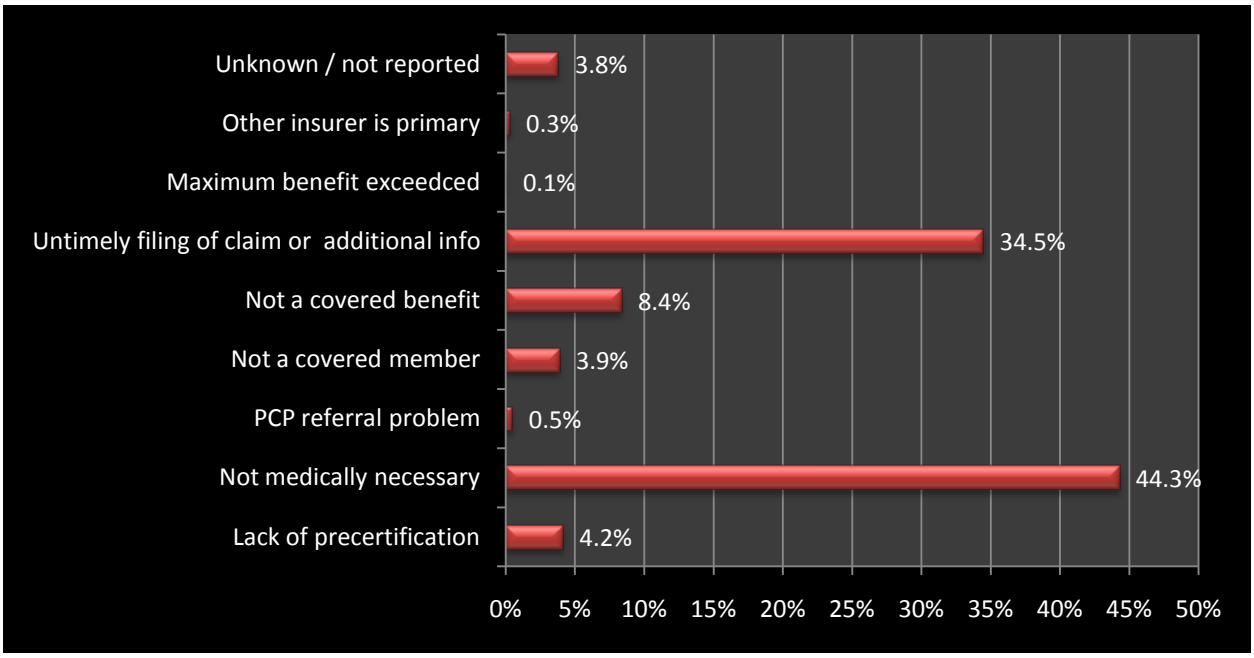
A patient was treated in ICU, but the insurer would only pay for standard inpatient care, claiming that the more intensive level of care was not medically necessary.

A physician ordered patient to inpatient status, but insurer asserted that patient met criteria for observation status only.

A claim was billed to insurance, but no payment or denial received. Since the medical provider failed to follow up with the insurer, the claim was ultimately written off.

An insurer requested ER reports, but they were not submitted within the contractually allowed time.

Figure 11: Claim Denials By Reason



The causes of claim denials are at least indirectly related to prompt pay issues. Medical providers report that claims handling processes and informational requests are often burdensome and overly complex, resulting in delays and ultimately denials when providers are unable to provide requested information within contractually defined deadlines. Several states have taken steps to encourage standardization of claim filings and to specify limits on the supporting documentation that may be required by insurers. These efforts are discussed in more detail in the following section.

Recommendations

Legislative Action

All states plus the District of Columbia have enacted *prompt pay* statutes requiring claims to either be paid or denied within specific timeframes, and imposing interest and penalties for failure to comply. Typically, prompt pay statutes require payment within 30 days of receipt for electronically submitted claims, and 45 days for claims submitted in paper form. Most statutes apply an interest penalty for failure to pay a claim within these time frames, most commonly 1% per month. A few states mandate incrementally higher interest rates based on the length of a claim processing delay. About a third of the states have a statutory *clean claim* definition, such that claims meeting the standard trigger statutory time frames and penalties for non-compliance. The simplest definitions mirror the Medicare definition (i.e., a claim with no defect or impropriety including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment). More extensive definitions consider the accurate and complete submission of uniform billing forms as a clean claim. More detailed statutes restrict permissible content for insurer informational requests, legal presumptions for actions contrary to legal standards, and data collection requirements to track provider and payer performance. A compendium of state prompt pay laws can be found in the appendices.

While medical providers have generally supported the enactment of prompt pay statutes, they remain dissatisfied as it has become apparent that many prompt pay statutes have had little practical effect. The evidence presented in this report supports, at least to some extent, the contention that claims handling processes are still mired in complexity and that medical providers still evidence an aging of A/R well beyond that generally found in other industries. Though the delivery of health care differs from many other industries, the degree of claim processing delays suggests significant room for improvement.

While it is worth emphasizing that the data are not strict evidence of statutory violations, clearly some strategy to ameliorate claim delays is warranted. Any such strategy should balance the legitimate concerns of insurers that they are permitted sufficient time to adequately

adjudicate claims and identify excessive or fraudulent charges with the equally legitimate concerns of medical providers that the claims process not be unnecessarily burdensome and that appropriate compensation is remitted in a timely fashion. Both legislative and regulatory action is warranted.

Prompt Pay Statute

Missouri's prompt pay statute became effective in January of 2002. The DIFP has taken numerous administrative actions pursuant this statute, including market conduct examinations and consumer investigations in response to complaints lodged by medical providers. Between 2003 and November 2009, the DIFP received a total of 1,577 complaints from medical providers regarding claims handling practices. The complaints were resolved with payouts of $1.7 million. In addition, an initial round of market conduct examinations completed in 2003 resulted in fines and forfeitures totaling $3.5 million, while subsequent examinations resulted in additional recoveries.[15] The department continues to actively investigate complaints received by medical providers.

Medical provider groups have expressed strong dissatisfaction with the Missouri prompt pay statute. The DIFP has also found the statute to be ambiguous in parts, so that strict enforcement can at times be difficult. While no recommendations with respect to specific statutory language are made, the following suggestions are offered for consideration.

Missouri's prompt pay statute is silent as to the information that insurers may require from medical providers. A few states have attempted to reduce the administrative burden on medical providers by establishing reasonableness standards regarding the types of information that an insurer can require from medical providers as part of the claim adjudication process. Such standards generally limit informational requests to data that is reasonably accessible to a medical provider and/or that are relevant to making a claim determination. For example, Texas limits

[15] Examinations often involve several areas of compliance. The DIFP does not explicitly track recoveries related to prompt pay violations, but only total recoveries.

requests to information that can be obtained from provider medical or billing records. Suggested standards include:

Reasonableness: The information required by insurers to process a claim should be reasonably available to medical providers. For example, insurers should not be able to require patient tax returns or police reports.

Relevancy: Informational requirements should be limited to that which is necessary to properly adjudicate a claim.

Transparency: All insurer requirements should be easily assessable and transmitted to medical providers in a timely fashion.

In addition, medical provider groups have identified two specific areas that they believe render Missouri's prompt pay statute ineffective: the lack of a *clean claim* definition, and the ability of insurers to *suspend* claims indefinitely. Of less import, it has been recommended that statutory time frames be expressed on a consistent basis, such as *processing days.*

Clean Claim

Nearly half of prompt pay statutes include a definition of *clean claim.* A clean claim is generally defined as a submission free from material defect or error and that conforms to minimal informational standards. A claim not considered *clean* thus contains information that is incomplete, inaccurate or otherwise inadequate for an insurer to properly assess their liability. In the context of a prompt pay statute, a claim satisfying the legal definition triggers time limits for disposing of a claim. In addition, more expansive definitions found in some states can create a degree of standardization and thereby reduce the administrative burden on healthcare providers associated with claims management. The Missouri prompt pay statute currently has no clean claim definition, so that insurers have a high degree of discretion to accept or reject the original claim filing.

Ten states have adopted the Medicare definition or some variation thereof: a clean claim "…has no defect, impropriety (including any lack of any substantial documentation) or particular circumstance requiring special treatment." The definition appears to simply require that claim rejections not be arbitrary or capricious, and any interpretation would have to revert to the contracts in place between providers and insurers. Medical providers in states that have adopted the Medicare definition have stated that it has little if any substantive impact on claims processing. Such broad language is also generally beyond the enforcement powers of state insurance regulators, who generally are unable to enforce provider contract provisions (other than insurance contracts), and disputes would have to be settled by legal action brought by medical providers.

Modifications of the Medicare definition generally offer clarifications of some of the key terms. For example, Iowa limits *circumstances requiring special treatment* to those instances in which

1. a reasonable suspicion of fraud exists
2. matters beyond an insurer's control, or "acts of God, insurrection, strike, fire,.."
3. Similar unique circumstances preventing timely payment

Six states have adopted novel definitions. For example, New Mexico considers a clean claim as a submission which

(a) "contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside the health plan's system,"
(b) and is not "materially deficient or improper, including lacking substantiating documentation currently required by the health plan, **or** [emphasis added]
(c) has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the health plan…"

The plurality of states with a clean claim definition tie the concept to a specific claim form, a list of data elements, or to forms insurers may promulgate so long as the forms are published and available to medical providers. Fifteen states have adopted this approach. The advantages

of this approach are the promotion of standardization and the potential to realize administrative efficiencies. In addition, the specificity and lack of ambiguity of these definitions create clearer rules that simplify enforcement.

The following table categorizes the different approaches among the states. More detail is provided in the appendices.

Table 6

Clean Claim Definitions		
Specify forms or data elements	**Medicare or modified Medicare**	**Unique definitions**
Alabama	Alaska	Arizona
Arizona	Indiana	District of Columbia
California	Kansas	Hawaii
Colorado	Louisiana	Mississippi
Delaware	Minnesota	New Mexico
Iowa	Oklahoma	South Dakota
Kentucky	Oregon	
Maine	Tennessee	
Maryland	Virginia	
Michigan	Washington	
Nebraska		
New Hampshire		
New York		
South Carolina		
Texas		
15 States	10 States	6 States

Any definition should consider ease of regulatory enforcement, the desirability of promoting standardization, and the degree of specificity such that the statute produces the desired substantive impact on claims handling. A general definition that merely attempts to constrain arbitrary rejections will most likely have little substantive impact on claims handling practices.

Suspensions

Missouri's statute requires that claims be disposed within 40 days of receipt, allowing for additional time to obtain necessary information from medical providers. In addition to payment or denial, a claim may be disposed by *suspension.* The suspension provision appears to be unique to the Missouri prompt pay statute. Insurers may suspend claims by "…giving notice to the claimant specifying the reason the claim is not yet paid, including but not limited to grounds as listed in the contract between the claimant and the health carrier." §376.383 Beyond the notification requirement, the statute provides no further limitations on the ability of insurers to suspend claims, thereby rendering many of the timelines ineffectual. Beyond accumulating 1 percent interest if the claim is eventually paid, suspended claims may remain in legal purgatory indefinitely, or until they are simply written off by frustrated providers.

The original purpose of the suspension provision appears to have been to provide insurers sufficient time to investigate atypical claim activity, especially activity pointing towards possible fraud. Insurers argued at the time of passage that fraud, or minimally excessive billing, was prevalent and exerted significant pressure on health care costs. However, the suspension provision provides no constraints on arbitrary action, whether such action is attributable to processing inefficiencies or produced by design. Nor does the statute provide a mechanism for the resolution of suspensions.

As such, it is recommended that the provision either be removed, or that clear parameters be established that would curtail possible abuses of the suspension process and limit suspensions to those instances that may legitimately require additional time to investigate. The elimination of suspension would require insures to either pay or deny claims within the prompt pay timeframes. Requiring insurers to deny rather than suspend claims would at a minimum force insurers to

provide specific and supportable grounds for the denial, such as those detailed in an earlier section (medical necessity, excluded benefit, etc). Such denials may be appealed. The issues implicated in denials are generally more tractable than are cases of possible fraud, and are subject to regularized and formal methods of disputation in a way that suspensions currently are not.

An alternative is to provide clear statutory limits on claim suspensions, though such an approach is subject to practical difficulties. Insurers have a legitimate interest in investigating excessive or inappropriate charges. However, it may be difficult to draft general rules that clearly delineate what such special cases may be that are not subject to abuse or that do not simply defer to insurers. If limiting language is preferred to an outright abolition, there are a number of alternative approaches:

- Make no attempt to define the circumstances in which a suspension may be appropriate, but rather establish a maximum permissible percentage of suspensions. For example, insurers might be limited some reasonable percent of all claims, or the cap could be based on the dollar amount of claims.

- Establish separate procedures governing how suspensions should be processed, including establishing appropriate time limits for their resolution and perhaps giving medical providers recourse to due process procedures to appeal suspensions. Currently, Missouri statute permits claims to be suspended indefinitely, essentially for any reason (i.e. for reasons "including but not limited to…")

Whatever method is selected, the revision or elimination of the suspension provision of the prompt pay statute is strongly recommended.

Timeliness Standards

The Missouri prompt pay statute contains two separate timeliness standards:

1. Insurers are assessed 1 percent interest per month on claims that remain unpaid after the 45th day of receipt. The interest is payable only if the claim is subsequently paid.

2. After receiving a claim, insurers are subject to timeliness standards governing any requests for additional information. Insurers are permitted to make up to two requests for such information. The initial request for additional information must be made within 10 days after receipt of the claim. After receipt of the requested information, the insurer has an additional 15 days to make a final request for any and all other information. After receipt of the final information, the claim must be disposed within 15 days. This standard is intended to prevent delays due to endless rounds of informational requests and to give insurers a reasonable time to gather information necessary to properly dispose of claims.

Thus, there are two timeliness standards: *45 calendar days* governing the accumulation of interest on unpaid claims, and *40 processing days* to dispose of a claim (pay, deny, or suspend). The second standard excludes the time intervals in which an insurer is waiting for responses to informational requests. Insurers have complained that the *45 calendar day* standard makes no allowances for instances in which claim processing delays are due to the failure of medical providers to submit requested information. The following hypothetical illustrates a claim disposed by the 105th day subsequent to receipt, even though the insurer is in compliance with the *40 processing days* standard.

Calendar days						
Day 1	**Day 8**	**Day15**	**Day 25**	**Day 35**	**Day 45**	**Day 70**
Processing days						
Day 1	**Day8**	**Clock stops**		**Day 9**	**Day 19**	**Clock Stops**
Claim Received	Insurer requests additional information	Information not received	Information not received	Information received insurer evaluates claim	Insurer makes second request for information, interest starts to accrue	Information not received

Calendar days		
Day 90	**Day 105**	**Total calendar days: 105. Out of compliance – two months interest payable.**
Processing days		
Day 20	**Day 35**	**Total processing days: 35. In compliance.**
Information received	Insurer pays claim	Total amount of claim paid + two months interest

Regulatory Action

The DIFP has not performed wide-ranging market conduct examinations specifically targeting prompt pay violations since 2003. That round of examinations resulted in $3.5 million in fines and penalties. While the DIFP has recently begun to more vigorously investigate prompt pay related complaints from medical providers, such investigations are limited in scope to the discrete issues brought to the attention of the DIFP by a complainant. Market conduct examinations are designed to investigate entire areas of insurer operations (such as claims handling), and are able to support inferences about overall insurer operations.

Market conduct oversight is clearly contemplated in the current statute as a primary enforcement mechanism. Section 376.384.3 directs the DIFP to "…monitor health carrier compliance with [this section]" via "examinations, which may be based upon statistical samplings." Compliance is defined as "…properly processing and paying ninety-five percent of all claims received in a given calendar year." Indeed, only the sampling approaches of market conduct exams can make inferences about the level of compliance as required by statute. Such inferences can only be based on scientific samples drawn from the relevant claim file population.

In addition, the DIFP may wish to consider the efficacy of developing more continuous monitoring capacities, as opposed to the more sporadic and costly methods associated with examinations. A few states routinely gather claims data from health carriers specifically structured to permit regulators to assess compliance with prompt pay statutes.

In the near-term, the DIFP's Division of Insurance Market Regulation will continue to investigate compliance with Missouri's prompt pay requirements to determine if examinations of particular insurers are appropriate. Pursuant to regulation, market conduct examination warrants may be issued if evidence indicates that an insurer may be "…engaging in any practice or course of business in violation…" of statute or regulation. Such evidence may be obtained from a variety of sources, including "market surveys" or "…any credible source with direct access to relevant information." 20 CSR 100.8.005(2)(C)(1 and 4) The extent of claim processing delays, and the large variation in claims processing observed across insurers, may be indicative of possible compliance failures.

Conclusion

Payment delays remain widespread seven years after enactment of the Missouri prompt pay statute. The analysis presented above has identified deficiencies in the current prompt pay statute, and suggested ways to ease the administrative burden of claims processing upon medical providers and decrease unnecessary claims processing delays. In addition, the DIFP will pursue a number of regulatory actions including, where appropriate, market conduct examinations of health insurance companies. It is hoped that this report will contribute to a constructive public dialogue and that various stakeholders will work together to balance the legitimate concerns of all parties with solutions that are efficacious, efficient, and fair.

Appendix A1

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
Alabama	Ala. Code 27-1-17	Clean electronic claims to be paid within 30 calendar days of receipt, 45 calendar days for clean written claims.	Interest: 1.5% per month, prorated daily. Admin Penalties: Discipline of insurer's license, fines not to exceed $100,000 per violation.	Yes. Definitions of clean electronic and clean written claims.	Alabama Department of Insurance http://www.aldoi.gov/ 334 269-3550
Alaska	Alaska Stat. 21.36.128	Clean claim to be paid within 30 days.	Interest at 15% accrues until date claim is paid.	Yes. Uses Medicare definition.	Alaska Division of Insurance http://www.dced.state.ak.us/insurance/ 907 465-2515
Arizona	Ariz. Rev. Stat. Ann. 20-3102	Clean claims to be paid within 30 days of receipt.	The state's legal interest rate.	Yes. Clean claim, defined at Sec. 20-3101, as one that can be processed without additional information.	Arizona Department of Insurance http://www.id.state.az.us/ 602- 364-2393
Arkansas	Ark. Rule and Regulation 43 Sec. 12(a)	Pay or deny clean electronic claim within 30 days after receipt; for claims submitted	Interest based on a formula: (the amount of the clean claim x 12% per annum x the number of days the	Sec. 12 mentions but does not define a "clean claim."	Arkansas Insurance Department http://www.insurance.arkansas.gov/ 501 371-2600 800 282-9134

A Compendium of State Prompt Pay Statutes						
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**	
		otherwise, 45 days.	delinquent payment period / by 365 days).			
California	Cal. Health & Safety Code Sec.1371.35	Health care service plans to pay complete claims ASAP, but no later than 30 working days after receipt; however, HMOs have 45 days after receipt.	Penalty of the > of $15 per year or 15% per annum, without requiring request therefore	Defines a "complete claim."	California Department of Insurance 213 897-8921	http://www.insurance.ca.gov/
Colorado	Colo. Rev. Stat. Ann. 10-16-106.5	Clean electronic claims to be paid, denied or settled within 30 days after receipt; claims submitted by other means within 45 days.	Interest: Depending on the situation 10% or, > than 90 days, 20% interest annually. Commissioner may investigate improper handling or denial of benefits.	Yes. Definition provided: a uniform claim form with all fields completed including required documents.	Colorado Division of Insurance 894-7499	http://www.dora.state.co.us/insurance/ 303

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
Connecticut	Conn. Gen. Stat. Ann. Sec. 38a-816(15)(B)	Payment not later than 45 days after receipt of proof of loss, filed in accordance with the insurer's practices or procedures.	Interest rate of 15% per annum, in addition to other potential penalties set forth in provision 15(B).		Connecticut Insurance Department http://www.ct.gov/cid/site/default.asp 860 297-3800 800 203-3447
Delaware	18 DE Admin. Code 1310(6.1)	Within 30 day after receipt, a clean claim shall be paid in whole, paid in part and denied in part, denied, or result in a request for additional information.	Interest: The maximum allowable lending rate under Delaware law. Payment of interest does not preclude Commissioner or the provider from other available remedies. Three failures to comply in 36 months creates rebuttable presumption insurer is engaged in an unfair practice.	Yes. Definition at provision 4.0 specifies several types of clean claims.	Delaware Insurance Department http://www.delawareinsurance.gov/ (302) 739-4251

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
Dist. of Col.	D.C. Code Ann. 31-3132(a), et seq.	Clean claim to be paid within 30 days after receipt.	Monthly interest at a progressive rate: 1.5%: 31-60 days 2%: 61-120 days 2.5%, thereafter. Sec. 31-3136 indicates pattern or practice of repeated violations may subject insurer to additional penalties.	Clean Claim defined in Sec. 31-3131. An expanded version of the Medicare definition.	D.C. Department of Insurance, Securities and Banking http://disb.dc.gov/ 202 727-8000
Florida	Title XXXVII, Section 627.613, et seq.	Insurers to reimburse claim within 45 days of receipt.	Simple interest at 10% per year.		Florida Office of Insurance Regulation http://www.floir.com/ 850 413-3140
Georgia	Ga. Code Ann., 33-24-59.5	Payment within 15 working days after receipt.	18% per year.		Office of Insurance and Safety Fire Commissioner http://www.gainsurance.org/ 404 656-2070 800 656-2298
Hawaii	Haw. Rev. Stat. Ann. 431:13-108(b)	Electronic claims to be paid in 15 days, paper claims within 30 days.	15% per year on valid, unpaid claims. The commissioner may also determine whether	Clean claim defined: a "covered" claim with no defects and no disputes and for which there is no	Hawaii Department of Commerce and Consumer Affairs http://hawaii.gov/dcca/ins/ 808 586-2790 808 586-2799

A Compendium of State Prompt Pay Statutes							
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**		
			penalties are appropriate.	reason to believe fraud exists.			
Idaho	Section 41-5602	Electronic claims to be paid within 30 days after receipt, paper claims to be paid within 45 days.	Interest at Idaho's contract statutory rate under Sec. 41-5603. The Director may impose an administrative fine up to $5,000 but shall not suspend or revoke the insurer's certificate. If the insurer is 95% compliant in a calendar year, no administrative penalty will be imposed. (41-5606)		Idaho Department of Insurance 334-4250	http://www.doi.idaho.gov/	208
Illinois	215 Ill. Comp. Stat. Ann. 5/357.9	Claim to be paid within 30 days following receipt.	9% per year.		Illinois Department of Insurance 217 782-4515	http://www.insurance.illinois.gov/	

A Compendium of State Prompt Pay Statutes						
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**	
Indiana	Ind. Code Ann. 27-8-5.7-6(a)(1)-(2)	Electronic claims to be paid within 30 days; paper claims within 45 days.	Interest at the average investment yield on state money in the prior fiscal year per IC 12-15-21-3(7)(A). Commissioner empowered to level civil fines based on on-time performance: 85%-95%, $10,000 60%-85%, $100,000 <60%, $200,000. (27-8--5.7-8)	Clean Claim definition consistent with Medicare's.	Indiana Department of Insurance 317 232-2385	http://www.in.gov/idoi/
Iowa	Iowa Code Ann. 507B.4(12) and Regulation 191-15.32.	Must accept, deny or pay a clean claim within 30 days of receipt.	10% per annum.	Clean claim defined in regulation thru a cross reference. (Reg. 191-15.32) Regulation also provides a definition of a "properly completed billing instrument."	Iowa Insurance Division 5705	http://www.iid.state.ia.us/ 515 281-

A Compendium of State Prompt Pay Statutes							
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**		
Kansas	Kan. Stat. Ann. 40-2441, 2442	Clean claim and any amendments thereto to be paid within 30 days after receipt.	1% per month until the claim is paid without requiring the person who filed the original claim to make any additional claim for such interest. Commissioner has cease and desist, suspension or revocation and fining authority under Sec. 1837.	Yes. Uses Medicare definition.	Kansas Insurance Department 296-3071	http://www.ksinsurance.org/	785
Kentucky	Ky. Rev. State. Ann. 304.17A-700 to 304.17A-730	Most clean claims to be paid or denied within 30 calendar days of receipt; those involving organ transplants, 60 days.	Uses a progressive interest rate: 1-30 days late, 12% per annum; 31-60 days late, 18% per annum; more than 60 days late, 21% per annum.	Yes. Properly completed billing instrument, names specific forms.	Kentucky Department of Insurance 800 595-6053	http://doi.ppr.ky.gov/kentucky/	

A Compendium of State Prompt Pay Statutes						
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**	
Louisiana	La. Rev. Stat. Ann. Title 22: Sections 1831-1838	If a paper claim and if submitted within 45 days of date of service, insurer has 45 days to pay, deny or pend. (Sec. 1832) Insurers have 25 days to pay, deny or pend an electronic claim. (Sec. 1833)	Interest of 12% per annum on the amount due. (Sec.s 1832 and 1833) Commissioner has cease and desist, suspension or revocation and fining authority. (Sec. 1837)	Yes. Uses Medicare definition.	Louisiana Department of Insurance http://www.ldi.state.la.us/ 800 259-5300 225 342-5900	
Maine	Me. Rev. Stat. Ann. tit. 24-A Sec. 2436(1)	Claims payable in 30 days after proof of loss is received and ascertainment of loss is made.	Interest at 1.5% per month for failure to pay an "undisputed claim" when due. Reasonable attorney's fees available.	Yes. Called an "undisputed claim."	Maine Bureau of Insurance http://www.maine.gov/pfr/insurance/ 624-8475	207
Maryland	Md. Code. Ann. Ins. 15-1005	Within 30 days of receipt, insurer shall pay or notify of status.	Uses a progressive interest rate: 31-60 days late, 1.5% 61-120 days late, 2% >120 days late, 2.5% To be paid without an	Yes. "Clean claim" defined by administrative rule COMAR 31.10.11.01, et al. Specific fields of the HCFA 1500 form	Maryland Insurance Administration http://www.mdinsurance.state.md.us/sa/jsp/Mia.jsp 410 468-2000 800 492-6116	

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
			additional claim for the interest.	(individual providers) and UB-92 form (hospitals) that must be completed are listed.	
Mass.	Mass. Gen. Laws Part 1, Title XXII, Chapter 176G Section 6	Within 45 days or receipt of completed forms, the insurer must make payment, notify of the reasons for nonpayment or notify in writing of the need for additional information.	Interest at 1.5% per month, not to exceed 18% per year.		Massachusetts Division of Insurance http://www.state.ma.us/doi/ 617 521-7794
Michigan	M.C.L.A. 500.2006 500.2006(8)(a)	A clean claim to be paid within 45 days after receipt; other claims, within 60 days.	Interest at 12% per annum. Commissioner may impose a $1,000 civil fine for each violation, up to $10,000 in the aggregate.	Yes. Provision (14) lists seven required elements.	Office of Finance and Insurance Services http://www.michigan.gov/dleg/0,1607,7-154-10555---,00.htm 517 335-4978

A Compendium of State Prompt Pay Statutes						
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**	
Minnesota	Minn. Stat. Ann. 62Q.75	Clean claim to be paid or denied within 30 calendar days of receipt.	Interest of 1.5% per month or any part of a month. The Commissioner may assess a financial penalty for a pattern of failure to comply.	Yes. Uses Medicare definition, but adds some language.	Minnesota Department of Commerce http://www.state.mn.us/portal/mn/jsp/home.do?agency=Insurance 651 296-6025	
Mississippi	Miss. Code Ann. 83-9-5(1)(h)(1)	Losses other than losses for which the policy provides any periodic payment may be paid as follows: electronic claims to be paid within 25 days, paper claims within 35 days.	Interest of 1.5% per month. Also authorizes a private right of action to recover unpaid amounts.	Yes. Uses Medicare definition, but adds some language. Also specifies what a clean claim does *not* include.	Mississippi Insurance Department https://www.mid.state.ms.us/ 359-3569	601

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
Missouri	Section 376.383.5, Revised Statutes of Missouri	Payment must be made within 45 days.	1% per month until the claim is paid without the necessity for a second claim for the interest. An additional penalty of $20 per day is possible in certain cases where the provider has notified the insurer that the claim remains unpaid. If the provider wins in court, reasonable attorney's fees are available.		Department of Insurance, Financial Institutions and Professional Registration http://insurance.mo.gov/ 573 751-4126
Montana	Mont. Code. Ann. 33-18-232	Claim to be paid within 30 days unless insurer reasonably requests additional information, and in that case, must be paid within 60 days.	10% interest annually. Also specifically states that noncompliance may not be the basis for a private cause of action.		State Auditor and Commissioner of Securities and Insurance http://www.sao.mt.gov/insurance/index.asp 406 444-2040

A Compendium of State Prompt Pay Statutes							
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**		
Nebraska	Neb. Rev. Stat. 44-8001 to 44-8010	Clean electronic claims to be paid within 30 calendar days of receipt, other (paper) clean claims, within 45 calendar days.	Interest: 12% per annum.	Yes. Means a completed form that meets an insurer's published requirements. 44-8004 also specifies what a "clean claim" does *not* include.	Nebraska Department of Insurance 471-2201	http://www.doi.ne.gov/	402
Nevada	Nev. Rec. Stat. Ann. 695C.185(1) (HMOs); NRS 689A.410 (Individual Health) and NRS 689B.255 (Group Health)	Claims to be approved or denied within 30 days of receipt. If more information is needed, within 30 days of the receipt of the information.	Interest: equal to the prime rate at the largest bank in Nevada, plus 6%.		Nevada Division of Insurance 687-4270	http://doi.state.nv.us/	775

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
New Hampshire	N.H. Rev. Stat. Ann. 415:6-h	Clean electronic claims to be paid within 15 calendar days, clean non-electronic claims in 30 calendar days. If additional information is needed, the claim must be adjudicated within 45 calendar days of receipt.	1.5% per month. Commission can discipline patterns non-compliance with fines not to exceed $300,000 a year, suspension or revocation, in addition to other available authority. Costs and attorney's fees are also authorized for private recoveries.	Yes. Means a fully completed claim form that meets the insurer's published requirements.	New Hampshire Insurance Department http://www.nh.gov/insurance/ 800 852-3416
New Jersey	N.J. Stat. Ann. 17B:30-54 (HCAPPA)	Electronic claims to be paid within 30 days, paper within 40.	12% interest annually, 10% on dental claims.		New Jersey Department of Banking and Insurance http://www.state.nj.us/dobi/index.html 609 292-7272
New Mex.	N.M. Stat. Ann. 59A-16-21.1	Electronic claims to be paid within 30 days; paper claims within 45 days.	1.5% monthly.	Yes. Includes Medicare language, but also requires substantially all data elements necessary for accurate adjudication.	New Mexico Public Regulation Commission http://www.nmprc.state.nm.us/id.htm 888 427-5772

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
New York	N.Y. Ins. Law 3224	Payment must be made within 45 days of receipt.	Interest: A rate set by the commissioner of taxation and finance for corporate taxes or 12% per annum. Civil administrative penalties not available to the Commissioner where insurer is 98% compliant.	Regulation Title 11, Chapter IX, Subpart 217-1.2 provides a list of the fields on the CMS 1500 from that must be completed.	New York State Insurance Department http://www.ins.state.ny.us/ 800 342-3736
North Car.	N.C. Gen. Stat. 58-3-225(b)(1)	Paper and electronic claims shall be paid within 30 calendar days of receipt, denied, or the claimant shall be notified that that the proof of loss was inadequate, that the claim was not submitted as required by the insurer, that coordination	18% per year.		North Carolina Department of Insuramce http://www.ncdoi.com/ 919 807-6860

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
		of benefits information is needed or that the claim is pending based on nonpayment of fees or premiums. (Instructions are provided on the required contents of each notification.)			
North Dakota	N.D. Cent. Code 26.1-36-37.1	All claims to be paid within 15 days.		Regulations 45-06-03.1-01 to -03 describes the required claim form formats, using CPT Codes, HCFA forms, etc.	North Dakota Insurance Department http://www.nd.gov/ndins/default.asp 701 328-2440 800 247-0560

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
Ohio	Ohio Rev. Code Ann. 3901.381(B)(1) See also 3901.38 to 3901.3814	Claim to be paid within 30 days if submitted on a standard form approved by the superintendent of insurance.	18% per year. (3901.389) Administrative remedies include monetary penalties, ordering the payment of interest, and cease and desist orders. (3901.3812).	Regulation 3901-1-59 specifies the contents of the standard health claim form authorized in the statute. CMS 1500, UB-82/UB 92, CMS 1450, NCPDP and J515 forms and their successors are approved.	Ohio Department of Insurance http://insurance.ohio.gov/Pages/default.aspx 614 644-2658
Okla.	Okla. Stat. Ann. tit. 36 Sec. 1219(A)	Payment must be made within 45 calendar days of receipt of a claim and any additional information and corrections. Insurer must notify within 30 calendar days of the need for corrections or additional information.	10% interest annually.	Yes. Essentially, the Medicare definition	Oklahoma Insurance Department http://www.ok.gov/oid/ 405 521-2828 800 522-0071

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
Oregon	Or. Rev. Stat. 743.866(1) Renumbered 743.911 (2007)	Clean claim to be paid or denied within 30 calendar days following receipt.	Interest at 12% per annum under (743.913)	Yes. Regulation 836-080-0080 uses the Medicare definition.	Oregon Department of Consumer and Business Services http://insurance.oregon.gov/ 503 947-7980
Penn.	40 Pa. Cons. Stat. Ann. 991.2166(a) (or 31 Pa. Code Section 154.18)	Payment must be made within 45 days.	10% interest annually.		Pennsylvania Insurance Department http://www.insurance.pa.gov/portal/server.pt/community/insurance_department/4679 717 787-2317
Rhode Island	R.I. Gen. Laws 27-18-61(a)	"Complete" electronic claims to be paid within 30 days, paper within 40. Each health plan is to establish a written standard of what constitutes a "complete claim."	Interest: 12% per annum, provided, however, that a plan in "substantial compliance" (i.e., pays on-time 95% of the time) is not obligated to pay such interest.		Rhode Island Department of Business Regulation, Insurance Division http://www.dbr.state.ri.us/divisions/insurance/ 401 462-9500

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
South Car.	S.C. Code Ann. 38-59-200 to 38-59-270	Payment within 20 business days of receipt of all information needed to constitute a clean electronic claim, 40 business days for a clean paper claim.	Interest: The legal rate of interest under 34-31-20(A) (i.e., 8 /34%). Director authorized to enforce via cease and desist orders, orders to correct errant business practices and to make payments, including interest, in addition to fines and license suspensions or revocations under 38-2-10.	Yes. A multi-component definition is provided in 38-59-210.	South Carolina Department of Insurance http://www.doi.sc.gov/ 803 737-6160
South Dakota	S.D. Codified Laws 58-12-20	Electronic claims to be paid within 30 days, paper claims within 45 days.	Section 58-12-21 specifically indicates that there is no private right of action.	Yes. Defined in 58-12-19 as one requiring no additional information to determine eligibility or to adjudicate the claim.	South Dakota Division of Insurance http://www.state.sd.us/drr2/reg/insurance/index.html 605 773-3563

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
Tennessee	Tenn. Code Ann. 56-7-109	Clean electronic claims to be paid within 21 days, 30 days for paper claims.	1% per month until the claim is paid. In addition, the Commissioner is authorized to issue cease and desist orders, conduct examinations and levy monetary penalties for the following levels of compliance: <95%, $10,000 <85%, up to $100,000 <60%, up to $200,000	Yes. Uses Medicare definition, but adds some language. Also specifies what is *not* a clean claim.	Tennessee Department of Commerce and Insurance http://www.tennessee.gov/commerce/index.shtml 615 741-2241

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
Texas	Tex. Ins. Code Ann. Sections 1301.131 to 1301.151	Clean electronic claims from preferred providers (i.e., within an HMO) must be paid within 30 days of receipt, 45 for non-electronic claims.	If the balance of the claim is paid after the 91st day after it is due under statute, an 18% annual interest rate applies. Before then there are three steps of gradually increasing penalties based on the lesser of a specific dollar penalty amount or a percentage of amounts related to the HMO contract. (See Section 1301.137)	Yes. Section 1301.131 specifies the standards for electronic and non-electronic claims in terms of federal and national "forms" (CMS 1500, etc.).	Texas Department of Insurance http://www.tdi.state.tx.us/ 800 252-3439

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
Utah	Utah Code Ann. 31A-26-301.6(3)(a)	Within 30 days of receipt of a written claim, the insurer shall pay the claim or deny the claim and provide a written explanation.	Interest rate based on a formula: For the first 90 days after due, the formula is: (the claim amount x the number of days late x .1%). Thereafter, the formula is: (the claim amount x the total number of days late beyond the 90-day point x the legal rate of interest under 15-1-1). The state's legal interest rate is currently 10%.		Utah Insurance Department http://www.insurance.utah.gov/ 801 538-3800
Vermont	Vt. Stat. Ann. Title 18 Section 9418	No less than 30 days following receipt of a claim the insurer shall pay the claim or notify the claimant it is contested or denied.	Interest: 12% per annum.		Vermont Department of Baking, Insurance, Securities and Health Care Administration, Insurance Division http://www.bishca.state.vt.us/InsurDiv/insur_index.htm 802 828-3301

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
Virginia	Va. Code Ann. 38.2-3407.15	Claims to be paid within 40 days of receipt unless there is an issue with the claim.	Computed daily at legal rate of interest. (See Section 38.2-4306.1)	Yes. Based on Medicare definition, but also includes claims where insurer fails to notify of defects.	Virginia State Corporation Commission, Bureau of Insurance http://www.scc.virginia.gov/division/boi/index.htm 804 371-9741
Washington	Wash. Admin. Code 284-43-321	Carriers shall pay providers as soon as practical subject to the following minimum standards: 95% of clean claims shall be paid within 30 days of receipt; 95% of all claim shall be paid or denied within 60 days.	Interest: 1% per month , calculated monthly as simple interest prorated for any portion of a month.	Yes. Used Medicare definition.	Washington State Office of the Insurance Commissioner http://www.insurance.wa.gov/ 360 725-7000 800 526-6900
West Vir.	W. Va. Code Ann. 33-45-2	Clean electronic claims to be paid within 30 days of receipt, clean manual claims within 40.	Interest: 10% per annum.	Yes. Based on Medicare definition, but also includes claims where insurer fails to notify of defects. Section 33-45-1	West Virginia Insurance Commission http://www.wvinsurance.gov/ 304 558-3354

A Compendium of State Prompt Pay Statutes					
State	**Statute Citation**	**Timeframes**	**Penalties**	**Clean Claim Definition**	**State Contact Information**
Wisconsin	Wis. Stat. Ann. 628.46(1)	Claim to be paid within 30 days.	12% per annum		Wisconsin Commissioner of Insurance http://oci.wi.gov/ 608 266-3585
Wyoming	Wyo. Stat. Ann. 26-15-124(a)	Claims to be rejected or accepted and paid within 45 days after receipt.	1Interest: 10% per year..		Wyoming Insurance Department http://insurance.state.wy.us/ 307 777-7401

Appendix A2

Clean Claim Definitions

Alabama

(1) CLEAN ELECTRONIC CLAIM. The transmission of data for purposes of payment of covered health care expenses that is submitted to an insurer, health service corporation, or health benefit plan which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the provider of the service or from a third party, in an electronic data format specified by the insurer's, health service corporation's, or health benefit plan's published filing requirements. In no event shall an insurer, health service corporation, or health benefit plan require that the health care provider submit data elements in excess of those required on the standard electronic health insurance claim format designated by Section 27-1-16 as a condition to the acceptance and processing of an initial claim as a clean claim.

(2) CLEAN WRITTEN CLAIM. A claim for payment of covered health care expenses that is submitted to an insurer, health service corporation, or health benefit plan on the claim form of the insurer, health service corporation, or health benefit plan which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the provider of the service or from a third party. In no event shall an insurer, health service corporation, or health benefit plan require that the health care provider submit information or data elements in excess of those required on the standard health insurance claim form designated by Section 27-1-16 as a condition to the acceptance and processing of an initial claim as a clean claim.

http://law.justia.com/alabama/codes/20286/27-1-17.html

Alaska

A claim that does not have a defect or impropriety, including a lack of any required substantiating documentation, or a particular circumstance requiring special treatment that prevents timely payment of the claim;

http://www.legis.state.ak.us/basis/folio.asp

Arizona 20-3101

A written or electronic claim for health care services or benefits that may be processed without obtaining additional information, including coordination of benefits information, from the health care provider, the enrollee or a third party, except in cases of fraud.

http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/20/03101.htm&Title=20&DocType=ARS

Arkansas

A claim for payment of health care expenses that is Submitted on a HCFA 1500, on a UB92, in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on the carrier's standard claim form with all required fields completed in accordance with the Health Carrier's published claim filing requirements. A Clean Claim shall not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent, (2) for benefits under a Medicare supplement policy if the claim is not accompanied by an explanation of Medicare benefits or the Explanation of Medicare Benefits ("EOMB") has not been otherwise received by the Health Carrier, or (3) for which the Health Carrier needs additional information in order to resolve one or more of the issues listed in Subsection 13(b) of this rule.

http://www.bing.com/search?q=Arkansas+Rule+and+Regulation+43&src=IE-Address

California

Complete claim.

A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other

format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. A plan shall specify, in a written notice sent to the provider within the respective 30- or 45-working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=01001-02000&file=1367-1374.19

Colorado

10-16-106.5. Prompt payment of claims – legislative declaration

2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

http://www.michie.com/colorado/lpext.dll?f=templates&fn=main-h.htm&cp=

Delaware

4.0 Clean Claim Defined4.1 A nonelectronic claim by a provider, other than an institutional provider, is a clean claim if the claim is submitted using the Centers for Medicare and Medicaid Services (CMS) Form 1500 or, if approved by the Commissioner or CMS, a successor to that form. Data for all relevant fields must be provided in the format called for by the form in order for the claim to constitute a clean claim.

4.2 A nonelectronic claim submitted by an institutional provider is a clean claim if the claim is submitted using the CMS Form UB-92, or, if approved by the Commissioner or CMS, a successor to that form. Data for all relevant fields must be provided in the format called for by the form in order for the claim to constitute a clean claim.

4.3 An electronic claim by a provider, including an institutional provider, is a clean claim if the claim is submitted using the appropriate ASC X12N 837 format in compliance with the standards specified at 45 CFR §162.1102 or any successor regulation.

4.4 If allowed by federal law, a carrier and provider may agree by contract to use fewer data elements than are required by the relevant form or format.

4.5 An otherwise clean claim submitted by a provider that includes additional fields, data elements, or other information not required by this Regulation is considered to be a clean claim for the purposes of this Regulation.

4.6 A claim by a policyholder that is submitted in the carrier's standard form using information called for by said forms, with all of the required fields completed, is a clean claim.

4.7 Any claim submitted by a provider or policyholder that includes an unspecified, unclassified or miscellaneous code or data element to constitute a clean claim shall also include appropriate supporting documentation or narrative which explains the unspecified, unclassified or miscellaneous code and describes the diagnosis and treatment or service rendered.

4.8 A claim for the same health care service provided to a particular individual on a particular date of service that was included in a previously submitted claim is a duplicate claim and does not constitute a clean claim.

http://regulations.delaware.gov/AdminCode/title18/1300/1310.shtml#TopOfPage

District of Columbia

31-3131

A claim that has no material defect or impropriety, including any lack of reasonably required substantiating documentation, which substantially prevents timely payment from being made on the claim or with respect to a health insurer that has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with § 31-3132. For the purposes of this paragraph, the term "material defect" means an imperfection in the submission of a claim consisting in the omission of information that is essential to process the claim in accordance with the health plan's published claim filing requirements. The requirements for electronic claim submissions shall be consistent with regulations promulgated by Secretary of Health and Human Services pursuant to section 1173 of the Social Security Act, approved August 14, 1935 (110 Stat. 2024; 42 U.S.C.S. § 1320d-2).

http://www.michie.com/dc/lpext.dll?f=templates&fn=main-h.htm&cp=dccode

Hawaii

§431:13-108 Reimbursement for accident and health or sickness insurance benefits.

"Clean claim" means a claim in which the information in the possession of an entity adequately indicates that:

(1) The claim is for a covered health care service provided by an eligible health care provider to a covered person under the contract;
(2) The claim has no material defect or impropriety;
(3) There is no dispute regarding the amount claimed; and
(4) The payer has no reason to believe that the claim was submitted fraudulently.

The term does not include:

(1) Claims for payment of expenses incurred during a period of time when premiums were delinquent;
(2) Claims that are submitted fraudulently or that are based upon material misrepresentations;
(3) Medicaid or Medigap claims; and
(4) Claims that require a coordination of benefits, subrogation, or preexisting condition investigations, or that involve third-party liability

http://www.capitol.hawaii.gov/hrscurrent/Vol09_Ch0431-0435E/HRS0431/HRS_0431-0013-0108.htm

Indiana

IC 27-8-5.7-2 "Clean claim" defined

Sec. 2. As used in this chapter, "clean claim" means a claim submitted by a provider for payment under an accident and sickness insurance policy issued in Indiana that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.
As added by P.L.162-2001, SEC.5.

http://www.in.gov/legislative/ic/code/title27/ar8/ch5.7.html

Iowa

191—15.32
507B
Prompt payment of certain health claims.
Effective July 1, 2002, the following provisions apply:
15.32(1)
Definitions and scope.

a. For purposes of this rule, the following definitions apply:

"Circumstance requiring special treatment"
means:

1. A claim that an insurer has a reasonable basis to suspect may be fraudulent or that fraud or a material misrepresentation may have occurred under the benefit certificate or policy or in obtaining such certificate or policy; or
2. A matter beyond the insurer's control, such as an act of God, insurrection, strike or other similar labor dispute, fire or power outage or, for a group-sponsored health plan, the failure of the sponsoring group to pay premiums to the insurer in a timely manner; or
3. Similar unique or special circumstances which would reasonably prevent an insurer from paying an otherwise clean claim within 30 days.

"Clean claim" means clean claim as defined in 2001 Iowa Acts, chapter 69, section 8(2b).

"Coordination of benefits for third-party liability" means a claim for benefits by a covered individual who has coverage under more than one health benefit plan.

"Insurer" means insurer as defined in 2001 Iowa Acts, chapter 69, section 7.

"Properly completed billing instrument"
means:

1. In the case of a health care provider that is not a health care professional:

- The Health Care Finance Administration (HCFA) Form 1450, also known as Form UB-92, or similar form adopted by its successor Centers for Medicare/Medicaid Services (CMS) as adopted by the National Uniform Billing Committee (NUBC) with data element usage prescribed in the UB-92 National Uniform Billing Data Elements Specification Manual, or
- The electronic format for institutional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; or

2. In the case of a health care provider that is a health care professional:

- The HCFA Form 1500 paper form or its successor as adopted by the National Uniform Claim Committee (NUCC) and further defined by the NUCC in its implementation guide; or
- The electronic format for professional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; and

3. Any other information reasonably necessary for an insurer to process a claim for benefits under the benefit certificate or policy with the insured contract.

This rule is intended to implement 2001 Iowa Acts, chapter 69, section 8, and Iowa Code section 507B.4 as amended by 2001 Iowa Acts, chapter 69.
http://search.legis.state.ia.us/nxt/gateway.dll/ar/iac?f=templates&fn=default.htm

Kansas

40-2441

Chapter 40.--INSURANCE
Article 24.--REGULATION OF CERTAIN TRADE PRACTICES

40-2441. Same; definitions. As used in K.S.A. 40-2440 through 40-2442 and amendments thereto:

(a) The term "clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under the Kansas health care prompt payment act.

http://www.kslegislature.org/legsrv-statutes/getStatute.do

Kentucky

304.17A-700 Definitions for KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123.
As used in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123:

(3) "Clean claim" means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:
(a) A clean claim from an institutional provider shall consist of:
1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;

2. Entries stated as mandatory by the NUBC; and
3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.
(b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.
(c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.
(d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;

http://lrc.ky.gov/KRS/304-17A/CHAPTER.HTM

Louisiana

SUBPART B. MEDICAL CLAIMS
§1831. Definitions
As used in this Subpart, the following terms shall be defined as follows:

(3) "Clean claim" means an accepted claim that has no defect or impropriety including any lack of required substantiating documentation or other particular circumstance requiring

http://www.legis.state.la.us/lss/lss.asp?doc=509001

Maine

§2436. Interest on overdue payments

2-A. Except as provided in this subsection, for purposes of this section, an "undisputed claim" means a timely claim for payment of covered health care expenses under a policy or certificate providing health care coverage that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes with all the required fields completed with correct and complete information in accordance with the insurer's published claims filing requirements. After October 16, 2003 and until October 16, 2005, for a provider with 10 or more full-time-equivalent employees, an "undisputed claim" means a timely claim for payment of covered health care expenses under a policy or certificate providing health care coverage that is submitted to an insurer in the insurer's standard electronic data format using the most current published procedural codes with all the required fields completed with correct and complete information in accordance with the insurer's published claims filing requirements. This subsection applies only to a policy or certificate of a health plan as defined in section 4301-A, subsection 7.
[2003, c. 469, Pt. D, §4 (AMD); 2003, c. 469, Pt. D, §9 (AFF) .]

http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2436.html

31.10.1102

(4) "Clean claim" means a claim for reimbursement submitted to a third-party payor by a health care practitioner, pharmacy or pharmacist, hospital, or person entitled to reimbursement, that contains:

(a) In the case of a health care practitioner or person entitled to reimbursement:

(i) The data elements required by Regulation .08 of this chapter, and

(ii) Any attachments requested by the third-party payor pursuant to Regulation .10 of this chapter;

(b) In the case of a hospital or person entitled to reimbursement;

(i) The data elements required by Regulation .09 of this chapter, and

(ii) Any attachments requested by the third-party payor pursuant to Regulation .10 of this chapter; or

(c) In the case of a pharmacy or pharmacist, the data elements set forth on the Universal Prescription Drug Claim Form or its electronic equivalent.

31.10.11.08

.08 Essential Data Elements for Clean Claims by Health Care Practitioners or Persons Entitled to Reimbursement.

A. In General. To qualify as a clean claim, a claim submitted to a third-party payor by a health care practitioner as provided in Regulation .03 of this chapter, or by a person entitled to reimbursement, shall conform to the applicable standard code set and include the following data elements:

(1) Subscriber's plan ID number (HCFA Form 1500, field 1a);

(2) Patient's name (HCFA Form 1500, field 2);

(3) Patient's date of birth and gender (HCFA Form 1500, field 3);

(4) Subscriber's name (HCFA Form 1500, field 4);

(5) Patient's address (street or P.O. box, city, and zip code) (HCFA Form 1500, field 5);

(6) Patient's relationship to the subscriber (HCFA Form 1500, field 6);

(7) Subscriber's address (street or P.O. box, city, and zip code) (HCFA Form 1500, field 7);

(8) Except in the case of a laboratory issued a license pursuant to Health-General Article, §17-205, Annotated Code of Maryland, patient status (HCFA Form 1500, field 8);

(9) Whether the patient's condition is related to employment (HCFA Form 1500, field 10(a));

(10) Whether the patient's condition is related to an auto accident (HCFA Form 1500, field 10(b));

(11) Whether the patient's condition is related to an accident other than an auto accident (HCFA Form 1500, field 10(c));

(12) Subscriber's policy number (HCFA Form 1500, field 11);

(13) Except in the case of a laboratory issued a license pursuant to Health-General Article, §17-205, Annotated Code of Maryland, subscriber's birth date and gender (HCFA Form 1500, field 11a);

(14) Except in the case of a laboratory issued a license pursuant to Health-General Article, §17-205, Annotated Code of Maryland, name of the third-party payor (HCFA Form 1500, field 11c);

(15) Disclosure of any other health benefit plans (HCFA Form 1500, field 11d);

(16) Patient's or authorized person's signature or notation that the signature is on file with the health care practitioner (HCFA Form 1500, field 12);

(17) Subscriber's or authorized person's signature or notation that the signature is on file with the health care practitioner or person entitled to reimbursement, if applicable (HCFA Form 1500, field 13);

(18) Except in the case of a laboratory issued a license pursuant to Health-General Article, §17-205, Annotated Code of Maryland, date of current illness, injury, or pregnancy (HCFA Form 1500, field 14);

(19) Except in the case of a health care practitioner for emergency services, or a laboratory issued a license pursuant to Health-General Article, §17-205, Annotated Code of Maryland, whether the patient has had the same or a similar illness (HCFA Form 1500, field 15);

(20) Except in the case of a health care practitioner for emergency services, the name of the referring physician or health maintenance organization (HCFA Form 1500, field 17);

(21) Hospitalization dates related to current services, if applicable (HCFA Form 1500, field 18);

(22) Diagnosis codes or nature of the illness or injury (HCFA Form 1500, field 21);

(23) Date of service (HCFA Form 1500, field 24A);

(24) Place of service codes for all claims, as designated by HFCA for Medicare (HCFA Form 1500, field 24B);

(25) Procedure code (HCFA Form 1500, field 24D);

(26) Diagnosis code by specific service (HCFA Form 1500, field 24E);

(27) Charge for each listed service (HCFA Form 1500, field 24F);

(28) Number of days, time (minutes), start and stop time, or units (HCFA Form 1500, field 24G);

(29) The carrier-assigned rendering provider number until the National Provider Identifier is developed and assigned, if applicable (HCFA Form 1500, field 24K);

(30) Health care practitioner's or person entitled to reimbursement's federal tax ID number (HCFA Form 1500, field 25);

(31) Patient's account number (HCFA Form 1500, field 26);

(32) Total charge (HCFA Form 1500, field 28);

(33) For claims:

(a) Submitted electronically, a computer-printed name as the signature of the health care practitioner or person entitled to reimbursement (HCFA Form 1500, field 31), or

(b) Not submitted electronically, the signature of the health care practitioner who provided the service, or person entitled to reimbursement who provided the service, or notation that the signature is on file with the HMO or preferred provider carrier (HCFA Form 1500, field 31);

(34) Name and address of the facility where services were rendered (if other than home or office) (HCFA Form 1500, field 32);

(35) Health care practitioner's or person entitled to reimbursement's billing name, address, zip code, phone number, and, if applicable, carrier-assigned provider number until the National Provider Identifier (NPI) is developed and assigned, including a provider number pursuant to Health-General Article, §19-710.1(b)(3), Annotated Code of Maryland, (HCFA Form 1500, field 33); and

(36) Any other field or essential data element necessary to comply with the applicable standard code set.

B. Specific Circumstances. In addition to the data elements required by §A of this regulation, to qualify as a clean claim, a claim submitted to a third-party payor by a health care practitioner or person entitled to reimbursement shall include the following data elements if circumstances exist that render the data elements applicable to the specific claim being filed:

(1) The other insured's or enrollee's name (HCFA Form 1500, field 9) is applicable if the patient is covered by more than one health benefit plan;

(2) The other insured's or enrollee's policy/group number (HCFA Form 1500, field 9a) is applicable if the patient is covered by more than one health benefit plan;

(3) The other insured's or enrollee's date of birth (HCFA Form 1500, field 9b) is applicable if the patient is covered by more than one health benefit plan;

(4) The other insured's or enrollee's plan name (employer, school, etc.) (HCFA Form 1500, field 9c) is applicable if the patient is covered by more than one health benefit plan;

(5) The other insured's or enrollee's HMO or insurer name (HCFA Form 1500, field 9d) is applicable if the patient is covered by more than one health benefit plan;

(6) Except in the case of a laboratory issued a license pursuant to Health-General Article, §17-205, Annotated Code of Maryland, the subscriber's plan name (employer, school, etc.) (HCFA Form 1500, field 11(b)) is applicable if the health benefit plan is a group plan;

(7) The prior authorization number (HCFA Form 1500, field 23) is applicable when prior authorization is required;

(8) A code pursuant to a global contract (HCFA Form 1500, field 24D) is applicable if the claim is between parties to a global contract;

(9) A code established by the Medicaid Program (HCFA Form 1500, field 24D) is applicable if the claim is for services rendered pursuant to Health-General Article, §15-103(b)(2), Annotated Code of Maryland;

(10) The modifier code (HCFA Form 1500, field 24(D)) is applicable when a modifier code is used to explain unusual circumstances;

(11) Whether an assignment was accepted (HCFA Form 1500, field 27) is applicable when an assignment has been accepted;

(12) The amount paid (HCFA Form 1500, field 29) is applicable if an amount has been paid to the health care practitioner or person entitled to reimbursement submitting the claim, by the patient or subscriber, or on behalf of the patient or subscriber; and

(13) The balance due (HCFA Form 1500, field 30) is applicable if an amount has been paid to the health care practitioner or person entitled to reimbursement submitting the claim, by the patient or subscriber, or on behalf of the patient or subscriber.

C. A third-party payor may not use or require a health care practitioner or person entitled to reimbursement to use any field for purposes that are inconsistent with these essential data elements or in addition to the applicable standard code set.

D. A third-party payor may accept a HCFA Form 1500 that includes data elements in addition to those set forth in §§A and B of this regulation.

Maryland (continued) 31.10.11.09

.09 Essential Data Elements for Clean Claims by Hospitals.

A. In General. To qualify as a clean claim, a claim submitted to a third-party payor by a hospital, or person entitled to reimbursement, shall conform to the applicable standard code set and include the following data elements:

(1) Hospital's, or person entitled to reimbursement's, name, address, and telephone number (HCFA Form UB-92, field 1);

(2) Patient's control number (HCFA Form UB-92, field 3);

(3) Type of bill code (HCFA Form UB-92, field 4);

(4) Hospital's, or person entitled to reimbursement's, federal tax ID number (HCFA Form UB-92, field 5);

(5) Beginning and ending date of claim period (HCFA Form UB-92, field 6);

(6) Patient's name (HCFA Form UB-92, field 12);

(7) Patient's address (HCFA Form UB-92, field 13);

(8) Patient's date of birth (HCFA Form UB-92, field 14);

(9) Patient's gender (HCFA Form UB-92, field 15);

(10) Patient's marital status (HCFA Form UB-92, field 16);

(11) Date of admission (HCFA Form UB-92, field 17);

(12) Admission hour (HCFA Form UB-92, field 18);

(13) Type of admission (for example, emergency, urgent, elective, newborn) (HCFA Form UB-92, field 19);

(14) Source of admission code (HCFA Form UB-92, field 20);

(15) Patient-status-at-discharge code (HCFA Form UB-92, field 22);

(16) Medical record number (HCFA Form UB-92, field 23);

(17) Responsible party name and address (HCFA Form UB-92, field 38);

(18) Value code and amounts (HCFA Form UB-92, fields 39—41);

(19) Applicable revenue code (HCFA Form UB-92, field 42) of:

(a) The Health Services Cost Review Commission, for hospitals located in the State, or

(b) The National or State Uniform Billing Data Elements Specifications, for hospitals not located in the State;

(20) Revenue description (HCFA Form UB-92, field 43);

(21) Service date (HCFA Form UB-92, field 45);

(22) Units of service (HCFA Form UB-92, field 46);

(23) Total charge (HCFA Form UB-92, field 47);

(24) Noncovered charges (HCFA Form UB-92, field 48);

(25) Name of the third-party payor (HCFA Form UB-92, field 50);

(26) Provider number (HCFA Form UB-92, field 51);

(27) Release of information (HCFA Form UB-92, field 52);

(28) Assignment of benefits (HCFA Form UB-92, field 53);

(29) Estimated amount due (HCFA Form UB-92, field 55);

(30) Subscriber's name (HCFA Form UB-92, field 58);

(31) Patient's relationship to the subscriber (HCFA Form UB-92, field 59);

(32) Patient's/subscriber's certificate number, health claim number, and ID number (HCFA Form UB-92, field 60);

(33) Treatment authorization code (HCFA Form UB-92, field 63);

(34) Principal diagnosis code (HCFA Form UB-92, field 67);

(35) Admitting diagnosis (HCFA Form UB-92, field 76);

(36) Attending physician ID (HCFA Form UB-92, field 82);

(37) Other physician ID (HCFA Form UB-92, field 83);

(38) Signature of the provider representative or notation that the signature is on file with the third-party payor (HCFA Form UB-92, field 85);

(39) Date the bill was submitted (HCFA Form UB-92, field 86); and

(40) Any other field or essential data element necessary to comply with the applicable standard code set.

B. Specific Circumstances. In addition to the data elements required by §A of this regulation, to qualify as a clean claim, a claim submitted to a third-party payor by a hospital, or person entitled to reimbursement, shall include the following data elements if circumstances exist that render the data elements applicable to the specific claim being filed:

(1) Covered days (HCFA Form UB-92, field 7) is applicable if Medicare is a primary or secondary payor;

(2) Noncovered days (HFCA Form UB-92, field 8) is applicable if Medicare is a primary or secondary payor;

(3) Coinsurance days (HFCA Form UB-92, field 9) is applicable if Medicare is a primary or secondary payor;

(4) Lifetime reserve days (HCFA Form UB-92, field 10) is applicable if Medicare is a primary or secondary payor and the patient was an inpatient;

(5) The discharge hour (HCFA Form UB-92, field 21) is applicable if the patient was an inpatient or was admitted for outpatient observation;

(6) The condition codes (HCFA Form UB-92, fields 24—30) are applicable if the HCFA Form UB-92 manual contains a condition code appropriate to the patient's condition;

(7) The occurrence codes and dates (HCFA Form UB-92, fields 32—35) are applicable if the HCFA Form UB-92 manual contains an occurrence code appropriate to the patient's condition;

(8) The occurrence span code and from and through dates (HCFA Form UB-92 field 36) are applicable if the HCFA Form UB-92 manual contains an occurrence span code appropriate to the patient's condition;

(9) HCPCS/Rates (HCFA Form UB-92, field 44) are applicable if there is a primary or secondary payor;

(10) A code pursuant to a global contract (HCFA Form UB-92, field 44) is applicable if the claim is between parties to a global contract;

(11) Prior payments (HCFA Form UB-92, field 54) are applicable if payments have been made to the hospital by the patient or another payor;

(12) The employment status code (HCFA Form UB-92, field 64) is applicable if there are payors of higher priority than the third-party payor, including workers' compensation;

(13) The employer name (HCFA Form UB-92, field 65) is applicable if there are payors of higher priority than the third-party payor, including workers' compensation;

(14) The employer location (HCFA Form UB-92, field 66) is applicable if there is workers' compensation involvement;

(15) Diagnoses codes other than the principal diagnosis code (HCFA Form UB-92, field 68—75) are applicable if there are diagnoses other than the principal diagnosis;

(16) Diagnoses codes describing the patient's signs, or presenting symptoms, or both (HCFA Form UB 92, field 76) are applicable for services provided in a hospital emergency department;

(17) The procedure coding methods used (HCFA Form UB-92, field 79) are applicable if the HCFA Form UB-92 manual indicates a procedural coding method appropriate to the patient's condition;

(18) The principal procedure code (HCFA Form UB-92, field 80) is applicable if the patient has undergone an inpatient or outpatient surgical procedure; and

(19) Other procedure codes (HCFA Form UB-92, field 81) are applicable as an extension of §B(17) of this regulation if additional surgical procedures were performed.

C. A third-party payor may not use or require a hospital to use any field for purposes that are inconsistent with these data elements or in addition to the applicable standard code set.

D. A third-party payor may accept the HCFA Form UB-92 that includes data elements in addition to those set forth in §§A and B of this regulation.

http://www.dsd.state.md.us/comar/getfile.aspx?file=31.10.11.02.htm

Michigan

500.2006 Payment of benefits on timely basis; payment of interest in alternative; failure to pay claims or interest as unfair trade practice; liability for claim pursuant to judgment; proof of loss; inability to pay claim; interest requirements; failure of reinsurer to pay benefits on timely basis; effect of inconsistency with certain acts; exceptions; processing and payment procedures; notices; violations; fines; definitions.

Sec. 2006.

(14) As used in subsections (7) to (13):

(a) “Clean claim” means a claim that does all of the following:

(i) Identifies the health professional, health facility, home health care provider, or durable medical equipment provider that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.

(ii) Sufficiently identifies the patient and health plan subscriber.

(iii) Lists the date and place of service.

(iv) Is a claim for covered services for an eligible individual.

(v) If necessary, substantiates the medical necessity and appropriateness of the service provided.

(vi) If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.

(vii) Identifies the service rendered using a generally accepted system of procedure or service coding.

(viii) Includes additional documentation based upon services rendered as reasonably required by the health plan.

http://www.legislature.mi.gov/(S(ykl2ooj1fbddh3i105arya45))/mileg.aspx?page=getObject&objectName=mcl-500-2006

Minnesota

62Q.75 PROMPT PAYMENT REQUIRED.

Subdivision 1.**Definitions.**

(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, including, but not limited to, coordination of benefits information, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim under this section. Nothing in this section alters an enrollee's obligation to disclose information as required by law.

https://www.revisor.mn.gov/statutes/?id=62Q.75

Mississippi

§ 83-9-5. Policy provisions.

(h) A provision as follows:

Time of payment of claims:

1. A "clean claim" means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

A clean claim does not include any of the following:

a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;

b. Claims which are submitted fraudulently or that are based upon material misrepresentations;

c. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or

d. Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

http://michie.com/mississippi/lpext.dll?f=templates&fn=main-h.htm&cp=

Nebraska

44-8002 Terms, defined.

For purposes of the Health Care Prompt Payment Act:

(2) Clean claim means a claim for payment of health care services that is submitted by a Nebraska health care provider to an insurer on a claim form with all required fields completed with information to adjudicate the claim in accordance with any published filing requirements of the insurer;

http://uniweb.legislature.ne.gov/laws/statutes.php?statute=44-8002

New Hampshire

415:6-h Prompt Payment Required

(a) ""Clean claim" means a claim for payment of covered health care expenses that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the insurer's published filing requirements.

http://www.gencourt.state.nh.us/rsa/html/XXXVII/415/415-6-h.htm

New Mexico

59A-16-21.1. Health plan requirements.

A. As used in this section:

(1) "clean claim" means a manually or electronically submitted claim from a participating provider that:

(a) contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the health plan's system;

(b) is not materially deficient or improper, including lacking substantiating documentation currently required by the health plan; or

(c) has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the health plan within thirty days of the date of receipt if submitted electronically or forty-five days if submitted manually; and

http://www.conwaygreene.com/nmsu/lpext.dll?f=templates&fn=main-h.htm&2.0

11 N.Y. Comp. Codes R. & Regs. 217-1.2

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW YORK
TITLE 11. INSURANCE DEPARTMENT
CHAPTER IX. UNFAIR TRADE PRACTICES
PART 217. PROCESSING OF HEALTH INSURANCE CLAIMS
SUBPART 217-1. PROMPT PAYMENT OF HEALTH INSURANCE CLAIMS
Current through October 15, 2009.

* Section 217-1.2.* Health insurance claim submission guidelines.

(a) A claim for payment of medical or hospital services submitted on paper shall be deemed complete if it contains the minimum data elements set forth in this Part. If the minimum data elements set forth are not present or accurate, the payer may, but need not, adjudicate the claim if the payer can determine, based on the information submitted, whether such claim should be paid or denied. Even if the claim is deemed complete, a payer may, pursuant to the provision of section 3224-a(b) of the New York Insurance Law, request specific additional information, distinct from information on the claim form, necessary to make a determination as to its obligation to pay such claim.

(b)

(1) In the case of a medical claim submitted on the national standard form known as a CMS 1500 (previously known as HCFA 1500 [New York State]) and its successors, attached as an appendix, (see Appendix 26 of this Title), the claim shall contain at least the items in the following fields of the claim form, except as provided in paragraph (2) of this subdivision:

1a. Insured's I.D. Number
2. Patient's Name
3. Patient's Date of Birth and Gender
4. Insured's Name (Last Name, First Name)
5. Patient's Address
9. Other Insured's Name (if appropriate)
9a. Other Insured's Policy or Group Number (if appropriate)
9b. Other Insured's Date of Birth and Gender (if appropriate)
9c. Employer's Name or School Name (if appropriate)
9d. Insurance Plan Name or Program Name (if appropriate)
10a. Is Patient's Condition Related to Employment?
10b. Is Patient's Condition Related to Auto Accident?
10c. Is Patient's Condition Related to Other Accident?
11. Insured's Policy, Group or FECA Number (if provided on ID Card)
11d. Is There Another Health Benefit Plan?

12. Patient's or Authorized Person's Signature (Can be completed by writing "signature on file" where appropriate)
13. Insured's or Authorized Person's Signature (if appropriate)
17. Name of Referring Physician or Other Source (if appropriate)
17a. I.D. Number of Referring Physician (if appropriate)
18. Hospitalization Dates Related to Current Services (if appropriate)
21. Diagnosis or Nature of Illness or Injury
23. Prior Authorization Number (to report ZIP code for ambulance pick-up) (if appropriate)
24A. Dates of Service
24B. Place of Service
24D. Procedures, Services, or Supplies
24E. Diagnosis Code (refer to item 21)
24F. $ Charges
24G. Days or Units (if appropriate)
25. Federal Tax I.D. Number
28. Total Charge
29. Amount Paid (if appropriate)
30. Balance Due
31. Signature of Physician or Supplier Including Degrees or Credentials (if not already on file, except as required by applicable Federal and State laws)
33. Personal Identifying Number of the particular practitioner rendering the care plus, if practicing in a group, the Identifying Number of the group as well

(2) For items listed in paragraph (1) of this subdivision with the notation "(if appropriate)", the generic nature of the standard claim form produces some instances when the information is not relevant in a particular instance. In those cases, the payer shall not insist upon completion of that item if the information is not relevant to the situation of that particular practitioner or patient or the information will not be used by the payer. If an item is not applicable at all, it should be left blank rather than inserting a notation that it is not applicable.

(c)

(1) In the case of a hospital claim submitted on the national standard form HCFA 1450 (also known as UB-92) and its successors, attached as an appendix (see Appendix 27 of this Title), the claim shall contain at least the items in the following fields of the claim form, except as provided in paragraph (2) of this subdivision:

1. Provider Name and Address
3. Patient Control Number
4. Type of Bill
5. Federal Tax Number
6. Statement Covers Period
7. Covered Days (if appropriate) (interim bill, etc.)
8. Non-Covered Days (if appropriate)
9. Coinsurance Days (if appropriate)
10. Lifetime Reserve Days (if appropriate)
11. Newborn Birthweight (if appropriate)
12. Patient Name
13. Patient Address
14. Patient Birthdate

15. Patient Sex
17. Admission Date
18. Admission Hour
19. Type of Admission
22. Discharge Status Code
42. Revenue Codes
43. Revenue Description
44. HCPCS/CPT4 Codes
45. Service Date
46. Service Units
47. Total Charges (by revenue code)
48. Non-Covered Charges
50. Payer Name
51. Provider ID
54. Other Insurance Payment (if appropriate)
55. Estimated Amount Due (if appropriate)
58. Insured's Name
59. Patient Relationship
60. Patient's Cert. SSN - HIC - ID No.
62. Insurance Group Number (if on card) (where appropriate)
67. Principal Diagnosis Code
68. Code
69. Code
70. Code
71. Code
72. Code
73. Code
74. Code
75. Code
76. Admitting Diagnosis Code
77. E-Code
78. DRG #
79. P.C.
80. Principal Procedure Code and Date
81. Other Procedures Code and Date
82. Attending Physician's ID Number
84. Remarks (to report ZIP code for ambulance pick-up) (if appropriate)

(2) For items listed in paragraph (1) of this subdivision with the notation "(if appropriate)", the generic nature of the standard claim form produces some instances when the information is not relevant in a particular instance. In those cases, the payer shall not insist upon completion of that item if the information is not relevant to the situation of that particular practitioner or patient or the information will not be used by the payer. If an item is not applicable at all, it should be left blank rather than inserting a notation that it is not applicable.

(d) Nothing in this Subpart shall prohibit a payer from electing to accept some or all claims with less information than that specified in the lists set forth in subdivisions (b) and (c) of this section.

http://weblinks.westlaw.com/result/default.aspx?cnt=Document&db=NY%2DCRR%2DF%2DTOC%3BTOCDUMMY&docname=344285700&findtype=W&fn=%5Ftop&ifm=NotSet&pbc=4BF3FCBE&rlt=CLID%5FFQRLT7239534571317l2&rp=%2FSearch%2Fdefault%2Ewl&rs=WEBL9%2E11&service=Find&spa=nycrr%2D1000&vr=2%2E0

Oklahoma

Chapter 1 Insurance code
Article 12 – Unfair Practices – Fraud – Deception
Section 1219 – Time for Processing Claims – Notice of Cause of Delay-Interest on Late Payment – Proof of Loss – Attorney's Fee

2. "Clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment; and

http://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=86431

Oregon

836-080-0080

Definition, Claims Handling Services; Claims Procedures and Information

(1) As used in sections 2 and 3, chapter 747, Oregon Laws 2001, "clean claim" means a claim under a health benefit plan that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

http://arcweb.sos.state.or.us/rules/OARS_800/OAR_836/836_080.html

South Carolina

SECTION 38-59-210. Definitions.

(8) "Clean claim" means an eligible electronic or paper claim for reimbursement that:

(a) is received by the insurer within one hundred twenty business days of the date the health care services at issue were performed;

(b)(i) when submitted via paper has all the elements of the standardized CMS 1500 or UB 04 claim form, or the successor of each as either may be amended from time to time; or

(ii) when submitted via an electronic transaction, uses only permitted standard code sets and has all the elements of the standard electronic formats as required by the Health Insurance Portability and Accountability Act of 1996 and other federal and state regulatory authority;

(c) is for health care services covered by the health insurance plan and rendered to an insured person by a provider eligible for reimbursement under the health insurance plan;

(d) has any corresponding referral that may be required for the applicable claim;

(e) is a claim for which the insurer is the primary payor, or for which the insurer's responsibility as a secondary payor has been clearly established;

(f) has no material defect, error, or impropriety that would affect the adjudication of the claim;

(g) includes all required substantiating documentation or coding;

(h) is not subject to any particular circumstance that the insurer reasonably believes, subject to review by the Department of Insurance, would prevent accurate or timely payment from being made on the claim under the terms of the health insurance plan, the participating provider agreement, or the insurer's published filing requirements; and

(i) is under a health insurance plan for which the insurer has been timely paid all applicable premiums.

http://www.scstatehouse.gov/code/t38c059.htm

South Dakota

58-12-19. "Clean claim" defined. As used in §§ 58-12-19 to 58-12-21, inclusive, the term, clean claim, means a claim for which there is no need for additional information to determine eligibility or adjudicate the claim. The term, clean claim, does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law or a claim for which fraud is suspected.

http://legis.state.sd.us/statutes/DisplayStatute.aspx?Statute=58-12-19&Type=Statute

Tennessee

56-7-109. Definitions — Timely reimbursement of health insurance claims. —

(a) Definitions. As used in this section:

(1) (A) "Clean claim" means a claim received by a health insurance entity for adjudication that requires no further information, adjustment or alteration by the provider of the services in order to be processed and paid by the health insurer. A claim is clean if it has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this section;

(B) “Clean claim” does not include a duplicate claim;

(C) “Clean claim” does not include any claim submitted more than ninety (90) days after the date of service; and

(D) “Clean claim” includes resubmitted paper claims with previously identified deficiencies corrected;

http://www.michie.com/tennessee/lpext.dll?f=templates&fn=main-h.htm&cp=tncode

Texas

Sec. 1301.131. ELEMENTS OF CLEAN CLAIM. (a) A nonelectronic claim by a physician or health care provider, other than an institutional provider, is a "clean claim" if the claim is submitted using the Centers for Medicare and Medicaid Services Form 1500 or, if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Claim Committee or the committee's successor. An electronic claim by a physician or provider, other than an institutional provider, is a "clean claim" if the claim is submitted using the Professional 837 (ASC X12N 837) format or, if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or the center's successor.

(b) A nonelectronic claim by an institutional provider is a "clean claim" if the claim is submitted using the Centers for Medicare and Medicaid Services Form UB-92 or, if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Billing Committee or the committee's successor. An electronic claim by an institutional provider is a "clean claim" if the claim is submitted using the Institutional 837 (ASC X12N 837) format or, if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or the centers' successor.

(c) The commissioner may adopt rules that specify the information that must be entered into the appropriate fields on the applicable claim form for a claim to be a clean claim.

(d) The commissioner may not require any data element for an electronic claim that is not required in an electronic transaction set needed to comply with federal law.

(e) An insurer and a preferred provider may agree by contract to use fewer data elements than are required in an electronic transaction set needed to comply with federal law.

(f) An otherwise clean claim submitted by a physician or health care provider that includes additional fields, data elements, attachments, or other information not required under this section is considered to be a clean claim for the purposes of this chapter.

(g) Except as provided by Subsection (e), the provisions of this section may not be waived, voided, or nullified by contract.
http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.1301.htm#1301.137

Virginia

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+38.2-3407.15

Washington

WAC 284-43-321 Provider Contracts—Terms and conditions of payment

(3) For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-321

West Virginia

§33-45-1.
Definitions.
As used in this article:

(2) "Clean claim" means a claim: (A) That has no material defect or impropriety, including all reasonably required information and substantiating documentation, to determine eligibility or to adjudicate the claim; or (B) with respect to which an insurer has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with section two of this article.

http://www.legis.state.wv.us/WVCODE/33/code/WVC%2033%20%20-%2045%20%20-%20%20%201%20%20.htm